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:**

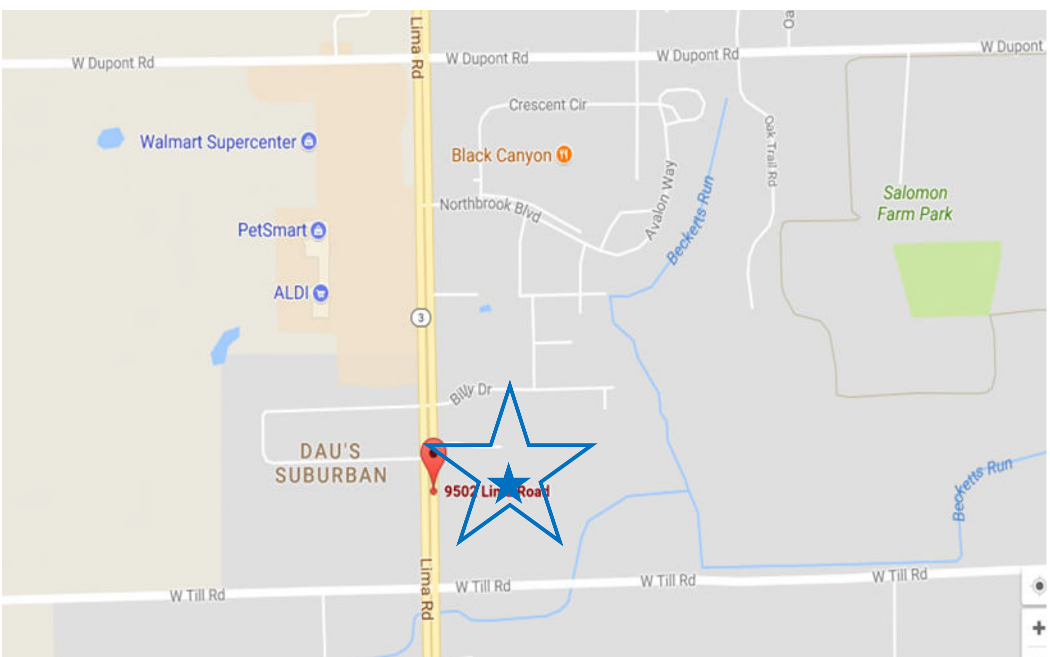
❶ **Complete this new patient paperwork and return it,** once it has been processed our office will contact you to schedule your consultation. Completed packets may be dropped off or faxed to our office, or emailed to frontdesk@spine-technology.com

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

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)
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___
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___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___

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
___	___
___	___
___	___

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:

0% 100%

STAR HEALTH

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

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: ____________________________

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.

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: ________________________

Your STAR Compliance Agreement and Expectations

Please Read Before Your Evaluation

STAR Health is designed to provide thoughtful medical care—not a menu of on-demand treatments.

Please **initial** each statement to confirm that you understand how our model works.

___ I understand that STAR Health is an interventional pain management facility and therefore, does not routinely prescribe and monitor narcotic pain medications.

___ I understand that STAR Health is diagnostic-first.

My visit begins with evaluating the problem rather than assuming in advance which treatment or procedure I should receive. We pride ourselves on taking on the toughest cases and making a diagnosis and providing appropriate treatment for this diagnosis. This detective process can take time, however. You must be willing to stick with the program. Not expect to be cured overnight.

___ I understand that my evaluation may be detailed.

My history, examination, imaging, movement and function, previous treatment, and response to care may all contribute to the clinical assessment.

___ I understand that an imaging finding is not automatically a diagnosis.

MRI, CT, X-ray, and other imaging may be important, but findings must be interpreted in the context of my symptoms and examination.

___ I understand that requesting a treatment does not mean that treatment will necessarily be recommended.

Injections, regenerative medicine options, medications, rehabilitation, additional testing, referrals, and other treatments are considered according to the clinical circumstances.

___ I understand that the appropriate next step may not be a procedure.

Further evaluation, rehabilitation, observation, additional testing, modification of the existing plan, or consultation with another clinician may sometimes be more appropriate.

___ I understand that if a procedure is recommended that does not automatically mean it is for long term benefit/pain relief.

Not all the procedures we recommend are meant for long term relief. We will often recommend a diagnostic injection (just numbing medication) into a structure to confirm the structure is the source of pain. This is to ensure we will be treating the appropriate area with a therapeutic procedure meant for prolonged management of symptoms.

___ I understand that the regenerative medicine process takes time.

If you are interested in orthobiologics or regenerative medicine (stem cell therapy to the lay person), keep in mind that these procedures are using your own immune system to eliminate inflammation and pain in an area of your musculoskeletal system. Often it will take 2+ months after these types of procedures to notice results. Sometimes they will need to be repeated as well.

___ I understand that STAR Health works to respect scheduled appointment times.

The practice generally runs on time, based on its scheduling record. However, medicine is not completely predictable.

___ I understand that another patient may occasionally require unexpected additional medical time.

A complex problem, new finding, important change in condition, or need for further explanation can require the physician to spend longer than originally anticipated.

___ I understand that this may occasionally delay my appointment.

A delay does not mean that my time is unimportant. It can occur because a medical issue could not reasonably have been predicted when the appointment was scheduled.

___ I understand that the same consideration regarding allotted time will be extended to me.

If my own medical situation requires additional time to clarify an important issue, answer necessary questions, or help me understand the recommended next steps, STAR Health will extend the same commitment to thoughtful care.

___ I understand that STAR Health is not organized around a consumer-style, menu-based healthcare model.

The objective is not to deliver whichever treatment happens to be requested or available. The objective is to determine what course of action is medically reasonable for my individual circumstances.

STAR HEALTH

___ I understand that I am an active participant in this process.

Accurate information, relevant records and imaging, questions, communication, and appropriate follow-through all help my healthcare team evaluate and manage my condition.

___ I understand that I may be asked to make healthy lifestyle changes, including rehab, in order to have a more successful outcome.

Patients who are compliant in the rehab process almost always have better outcomes than patients who do not relate to rehab and/or don't put the effort in. We (as a society) are conditioned to believe a surgery or pharmaceutical can fix any problem quickly. If this is how you think, the STAR Health program is probably not for you. We believe in forming a therapeutic partnership to help relieve your pain and get you functioning at a higher level - without medications or risky surgeries.

Our Commitment to One Another

We will respect your time.

We will also respect the medical complexity of the patient in front of you.

If you are that patient, we will extend the same commitment to you.

Patient Name: ____________________________________

Patient Signature: ________________________________