Welcome to Algos Pain & Spine Care. It is our goal to accurately diagnose your medical problem so that we can find the best way to treat it. In doing so, we need vital information from you. We know that filling out these forms can be difficult, but please complete them carefully.
Your accurate responses will give us a better understanding of you and your medical issues. From this information we gather, we can provide you with the best medical care possible.

Please follow the directions, clearly mark your answers, circle appropriate responses, or write legibly where indicated. If you have any questions, please call the office at 224.998.0900.

Filling this out prior to the date of your appointment will make the process faster and easier.

Thank you for your cooperation and we look forward to treating you.

Sincerely,

The Staff at Algos Pain & Spine Care

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Today's Date: _____

Patient's Full Name:_____

Date of Birth:_____ Age:_____ Sex: ❑ M ❑ F

Race: _____ Ethnicity: ❑ Non-Hispanic ❑ Hispanic

Marital Status: ❑ Married ❑ Single ❑ Separated ❑ Divorced ❑ Widowed

Address:_____City:_____

_____ State:_____ Zip:_____

Home Phone:_____ Cell phone:_____

Email Address: _____

Occupation: _____ Employer Name and Phone Number: _____

Employment Status: ❑ Full time ❑ Part time ❑ Unemployed ❑ Retired ❑ Student ❑ Other:_____

If over age 65, do you have an Advance Directive? ❑ Yes ❑ No

(If yes please check the following, ❑Do Not Intubate ❑Do Not Resuscitate)

If over age 65, are you at risk for fall injuries? ❑ Yes ❑ No

If yes, please check the following:

❑No falls in the past year ❑ One fall with injury in the past year

❑Two or more falls with injury in the past year ❑ One fall without injury in the past year

❑ Two or more falls without injury in the past year

IN CASE OF EMERGENCY:

Emergency Contact Name: _____ Phone_____

Relationship:_____

Pharmacy Name and Location:

_____

Referring Physician: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number:_____

Is visit related to: Workman's Compensation? Yes ( ) No ( ) Motor Vehicle Accident? Yes ( ) No ( )

If yes: Date of injury: _____ Claim No. _____

Insurance Carrier:_____

Address: _____ City: _____ Zip: _____

Phone: _____ Contact Person: _____

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Medication Reconciliation

Please list all of your medications, including eye drops, over-the-counter and alternative medications. It is extremely important for your care and safety that your provide complete and accurate information. Medications should be continued at home unless specified to discontinue by physician.

Patient Name: _____ **DOB:**_____

MEDICATION LIST – List all meds including over the counter, herbals, & supplements

Allergies: **None** **Latex** **Contrast Dye** **Other:**_____

Type of Reaction (hives, difficulty breathing etc.): _____

HEALTH HISTORY

If any applies, check the box:

❑Hypertension (High Blood Pressure)	❑Cancer Type: _____	❑Tuberculosis
❑Hypercholesterolemia (High Cholesterol	❑Erectile Dysfunction	❑Dialysis
❑Hyperthyroidism (Overactive Thyroid)	❑Diabetes Type I or Type II	❑Fibromyalgia
❑Hypothyroidism (Underactive Thyroid)	❑Hepatitis	❑Menstrual problems
❑Heart Attack	❑Degenerative arthritis	❑Rheumatoid arthritis
❑Cardiac arrest	❑Osteoporosis	❑Epilepsy or Seizures
❑Abnormal EKG	❑ Heart Pacemaker	❑ COPD
❑Angina Pectoris	❑Varicose Veins	❑HIV/AIDS
❑Asthma	❑Schizophrenia	❑Stomach ulcers
❑Stroke	❑Incontinence	❑Stomach/Intestinal/GI Disease
❑Depression	❑Anxiety	❑Bipolar

Other Health History (not listed): _____

Family Health History: _____

List any **SURGERIES** you have had (month/year): _____

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Patient Name: _____ Age: _____

REVIEW OF SYSTEMS

Do you have any of the following? Please check Yes or No for each item.

General:

Recent weight loss of more than 10 pounds	❑ Yes	❑ No
Recent weight gain of more than 10 pounds	❑ Yes	❑ No
Seen primary care physician in last year	❑ Yes	❑ No
Fever	❑ Yes	❑ No
Chills	❑ Yes	❑ No
Night sweats	❑ Yes	❑ No

Cardiac:

Chest pain	❑ Yes	❑ No
Shortness of breath	❑ Yes	❑ No

Respiratory:

Wheezing	❑ Yes	❑ No
Pneumonia	❑ Yes	❑ No
Chronic cough	❑ Yes	❑ No

Gastrointestinal:

Abdominal pain	❑ Yes	❑ No
Nausea	❑ Yes	❑ No
Vomiting	❑ Yes	❑ No
Diarrhea	❑ Yes	❑ No
Liver problems	❑ Yes	❑ No

Skin:

Open sores	❑ Yes	❑ No
New moles	❑ Yes	❑ No
Poor healing	❑ Yes	❑ No
Skin infection	❑ Yes	❑ No

Hematologic/Oncologic:

Easy bruising	❑ Yes	❑ No
Blood thinning	❑ Yes	❑ No
Blood transfusion	❑ Yes	❑ No
Organ transplant	❑ Yes	❑ No

Bone/Joints:

Shoulder pain	❑ Yes	❑ No
Wrist or hand pain	❑ Yes	❑ No
Hip pain	❑ Yes	❑ No
Knee pain	❑ Yes	❑ No
Lupus	❑ Yes	❑ No
Muscle weakness	❑ Yes	❑ No
Fibromyalgia	❑ Yes	❑ No

Genitourinary:

Abnormal kidney function	❑ Yes	❑ No
Pain with urination	❑ Yes	❑ No
Frequent urinary infections	❑ Yes	❑ No

Mental Health:

Sleep disturbance	❑ Yes	❑ No
Feeling of hopelessness	❑ Yes	❑ No

Nervous System:

Headaches	❑ Yes	❑ No
Tremors	❑ Yes	❑ No
Poor speech	❑ Yes	❑ No
Changes in vision	❑ Yes	❑ No

Endocrine:

Thyroid problems ❑ Yes ❑ No

Please mark the areas where you experience the following sensations; please pay attention to which side you are indicating:

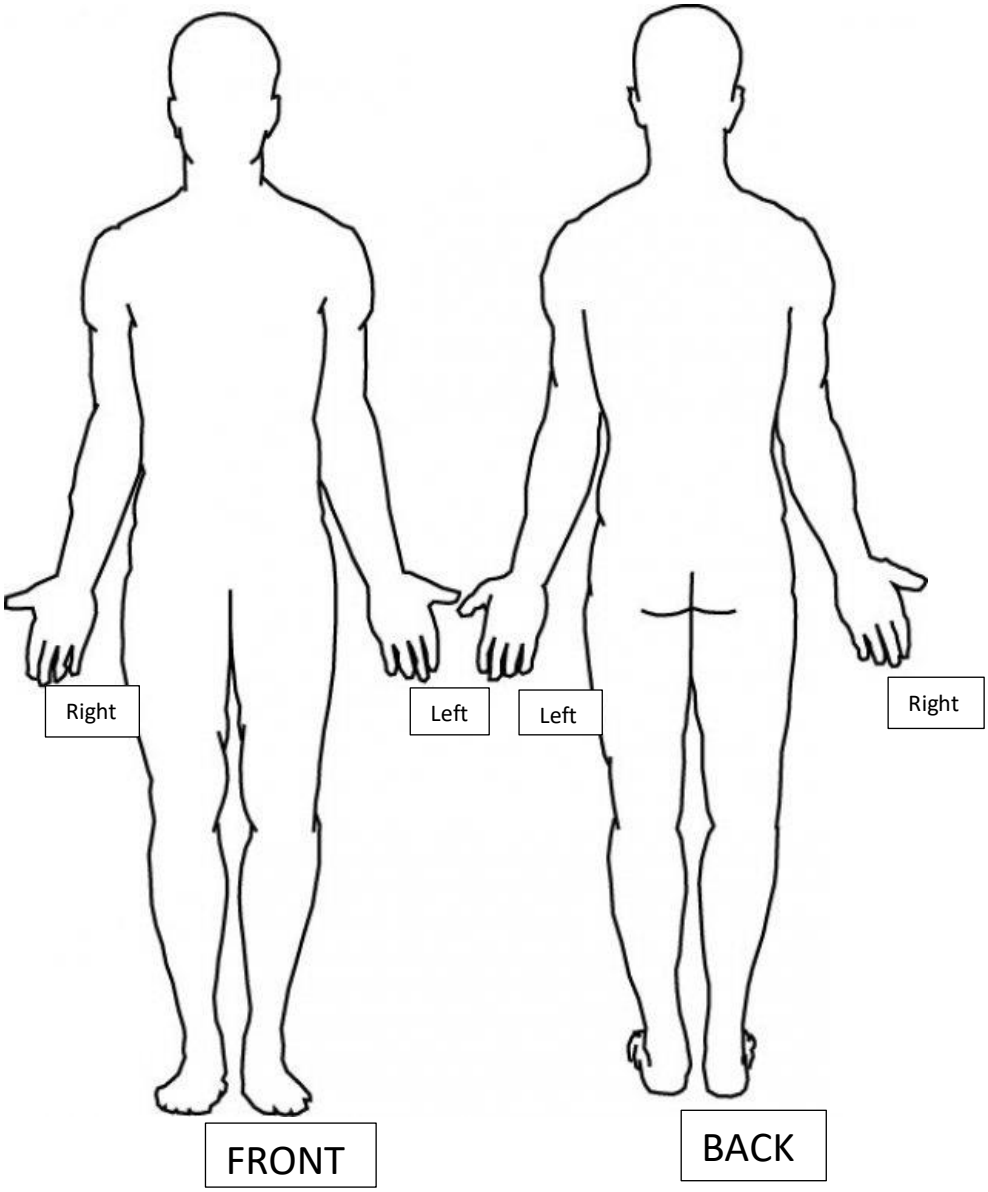
Ache
^^^^^
^^^^^
^^^^^

Numbness
OOOO
OOOO
OOOO

Pins &
Needles
====
====
====

Burning
XXXX
XXXX
XXXX

Stabbing
/ / / / /
/ / / / /
/ / / / /



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How long have you had this pain? _____ Is this pain due to an **injury** (circle): YES NO

If yes, please explain: _____

With time, this pain is getting (circle): **Worse / Better / Unchanged**

Rate your pain on a scale of 0 – 10 (0= NO PAIN 10=WORST PAIN): _____

This pain is: ❑ Always present and hurts the same all the time
❑ Always present but hurts worse at times
❑ Intermittent – it comes and goes depending on what I'm doing

How does each of the following affect your pain (mark all that apply):

Sitting:	❐Better	❐Worse	❐No change
Standing:	❐Better	❐Worse	❐No change
Walking:	❐Better	❐Worse	❐No change
Lying down:	❐Better	❐Worse	❐No change
Rising from a chair:	❐Better	❐Worse	❐No change
Applied heat:	❐Better	❐Worse	❐No change
Applied ice:	❐Better	❐Worse	❐No change
Massage:	❐Better	❐Worse	❐No change
Physical activity:	❐Better	❐Worse	❐No change
Cold weather:	❐Better	❐Worse	❐No change
Bending forward:	❐Better	❐Worse	❐No change

If you have problems with any of the following, mark all that apply:

Bladder control (accidents):	❐No problem	❐Can't empty bladder	❐Loss of control
Bowel control (accidents):	❐No problem	❐Constipation	❐Loss of control
Arm/Leg strength:	❐No problem	❐Weakness	❐Loss of control

I have tried the following to treat the pain (mark all that apply):

Previous Treatments	**Yes/No**	**Was the treatment helpful?** (No help, Short term relief, Helped a lot)
Physical Therapy		
Chiropractic		
Surgery		
Psychologist		
Medications		
Injections		

List all the **pain medications** you've tried:

_____

List all the **Injections** (with dates) you've had:

_____

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Do you take any **blood thinners?** ❑ No ❑ Yes - If yes, mark below all that apply

❑Eliquis (Apixaban) ❑Aspirin ❑Plavix (Clopidogrel) ❑ Xarelto (Rivaroxaban)

❑Coumadin (Warfarin) ❑Pradaxa (Dabigatran) ❑Other: _____

Nicotine: ❑ I don't smoke
❑ I smoke _____ packs/day and I've smoked for _____ years.
❑ I did smoke _____ packs/day but I quit smoking _____ years ago

Drugs: ❑ I don't use any illicit drugs
❑ I use the following illicit drugs:_____

Alcohol: ❑ I don't drink
❑ I drink (circle): Occasionally Monthly Weekly Daily (_____ drinks/day)

Is there anything else you believe is important for us to know? ❑ No ❑ Yes

If yes, please explain:

_____

_____

PHYSICIAN & STAFF USE ONLY

Imaging: MRI C / T / L *(Staff to include imaging report)*	Plan:

_____ _____
Patient Signature Date

_____ _____
Verifying Staff Signature Date

NOTE: By signing this form, you are verifying that all information is accurate and complete.

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HIPAA Notice of Privacy Practices

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our Office Manager in person or by phone at our main phone number. Please return this signed form to the front desk to be placed in your patient file.

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information regarding my medical condition may be disclosed to:

Name: _____

Phone Number: _____

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Algos Pain & Spine Care

FINANCIAL RESPONSIBILITY:

I hereby authorize and direct my insurance carriers, including Medicare, private insurance and any other health/medical plan, to issue payment checks directly to Algos Pain & Spine Care for medical services rendered to myself and/or dependents regardless of the benefit. I understand that I am responsible for any amount not covered by insurance. I hereby authorize Algos Pain & Spine Care to pursue any means necessary to collect all charges on my account if allowable under law. I have requested medical services from Algos Pain & Spine Care if the relevant insurer, plan or payor does not pay the billed amount in full.

I hereby authorize Algos Pain & Spine Care to:
(1) release any information necessary to insurance carriers regarding my medical condition and treatment:
(2) to process insurance claims generated in the course of examination or treatment
(3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

_____ _____ _____
Signature Print Name(s) Date

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PATIENT AGREEMENTS AND AUTHORIZATION

I understand that I require treatment in this facility because of my condition. I permit my physician(s) or his employees, and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care may include tests, nursing care, examinations, and medical and surgical treatment.
I recognize it is the responsibility of my physician to explain to me the nature of any diagnostic tests and medical and/or surgical procedures judged by him as necessary for my treatment and to advise me of risks and consequences of such procedures. I acknowledge that no guarantees have been made to me by my physician as to the result of any treatments, examinations, and/or operative procedures performed in the physician's office.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION:
I hereby authorize the physician involved with my care to release information from my medical record as may be required to any person, corporation, or agency which is legally responsible or has good cause to believe is legally responsible for processing and/or paying all or any part of the physician's charges and/or professional fees to which any entity designated by me for discharge and planning purposes.

Medicare Consent (If applicable)
I certify that the information given by me in applying for payment under title XVIII (Medicare) of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to information to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medical claim. I request that payment of authorized benefits may be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. The Medicare intermediary advises that the type of services may no longer qualify as covered under Medicare.

Assignment of Benefits/Financial
I hereby assign payment directly to Algos Pain & Spine Care all insurance benefits payments (including any major medical payments) due to me as a result of the named patient's outpatient treatment or service and pursuant to any insurance contract I have which provides for such treatment. I agree to be responsible for any charges incurred that are not paid by insurance or other third-party payers.

CANCELLATION POLICY/NO-SHOWS
I acknowledge and understand that the appointment cancellation policy requires me to contact the office 24 hours in advance of my scheduled appointment to reschedule or cancel my appointment and avoid a charge of **$25.00.** This fee is not covered by insurance and must be paid prior to next appointment. Multiple no show or cancelled appointments in any 12-month period may result in termination for our practice. I agree to pay Algos Pain and Spine Care this fee on each occasion that I fail to comply with the cancellation policy.

By signing this document, I acknowledge that I have read and understand this consent. Further, I hereby consent and authorize this facility to use or disclose my Protected Health Information in conjunction with treatment, payment or health care operations in accordance with the terms of consent.

_____ _____
Patients Signature Printed Name and Date

_____ _____
Responsible Agent or Legal Guardian Signature Printed Name and Date

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FINANCIAL POLICY

We are pleased that you have chosen Algos Pain & Spine Care for your healthcare. We are committed to providing you with the best possible care. We encourage you to discuss with us any concerns you have about our professional fees and financial policies. While we will make every attempt to assist you by filing insurance claims, payment for services is your responsibility.

Dr. Cha has a financial interest in Algos Pain & Spine Care. A financial interest through equity, debt or other means in the clinic. Any physician who has financial interest in Algos Pain & Spine Care is required to inform patients prior to scheduling their procedures/services at Algos Pain & Spine Care. As a patient, you are free to choose Algos Pain & Spine Care or any other facility for your procedure/services required, without penalty, subject to any limitations of your health insurance plan.

Medicare
We accept Medicare assignment and will file with your supplemental insurance.

Worker's Compensation
We will submit claims to your employer or their insurance carrier for work related injuries. In order to do this, we must have authorization from the employer and accurate billing address, contact person's name and a phone number

Liability/MVA
If you sustained injuries from a motor vehicle accident or other accident, you must provide us with complete insurance information including company name, phone number, billing address and contact person's name so we can file the claim for you. Any payments made directly to you by your insurance company must be signed over to Algos Pain & Spine Care. Failure to do so may result in you being discharged from the practice and or sent to collection agency.

Attorney
We do not bill attorneys. We expect payment at the time of service and consider the patient, not his attorney to be financially responsible for the medical services received. In certain circumstances, we will accept a letter of protection.

Treatment of Minors
Although we will file claims with the appropriate insurance company, the adult accompanying a minor will be responsible for the medical services received.

No Insurance
We expect payment at the time of service. If this presents a financial hardship, please discuss this with our financial advisor so a payment arrangement can be made.

Returned Checks
A $25 fee will be imposed on all returned checks.

Billing Questions:
If you have any billing questions, call our office at 224.998.0900 EXT. 206

I have read and understand this financial policy.

Patient Signature: _____ Date: _____