Medical Pain & Spine Care of Indiana
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**Thank you** for choosing Medical Pain & Spine Care of Indiana (MPSCI) to provide your comprehensive pain management care.

Your appointment is scheduled for _____

Please arrive 15 minutes prior to your first appointment and bring the following information with you:

1) ALL of your current medications in pharmacy bottles to your initial visit.
2) Any X-rays, MRIs, and/or CT scans you may have had done that pertain to the reason you are being seen in our pain clinic.
3) Insurance cards, referrals if required by your insurance, and your driver's license or ID card.
4) The enclosed completed patient health history packet (below). If you cannot complete the paperwork yourself, please have a family member assist you prior to your scheduled appointment.

If X-rays and MRI films have not already been sent by your referring physician, they are available at the facility where you had them performed. To avoid delay in treatment, please contact the facility and request copies be provided to you for this appointment.

In the event that you are unable to keep your scheduled appointment, kindly give our office at least 24 hours notice. **Missed office appointments** are subject to a **$25** fee which must be paid before future appointments may be scheduled. **Missed procedure appointments** are subject to a **$100** fee which must be paid before future appointments may be scheduled. Please be prepared to pay any applicable insurance co-payments at the time of service.

*It is our privilege to treat you!*

# PATIENT REGISTRATION FORM

Today's Date _____/_____/_____

Patient Name_____DOB_____/_____/_____

Patient Address_____Gender M or F

City/State/Zip_____SSN_____

Home Phone_____Work Phone_____Cell Phone_____

Employer Name_____

Address_____Phone_____

Primary Care Physician_____ Referring Physician_____

**GUARANTOR (person responsible for all balances on the account)**

Name_____Relationship_____

Address_____

City/State/Zip_____SSN_____

Home Phone_____Cell Phone_____DOB_____

Employer_____Employer Phone_____

**INSURANCE INFORMATION**

Primary_____Policy Holder_____DOB_____

Employer_____ID_____Group_____SSN_____

Secondary_____Policy Holder_____DOB_____

Employer_____ID_____Group_____SSN_____

**EMERGENCY CONTACT**

Name_____Relationship_____Phone_____

Are there any religious or cultural beliefs that will direct your medical care that we should be aware of? Y or N

**Signature**_____**Date**_____

# CONSENT TO TREAT

I request and give my consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs, and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon.

**PLEASE INITIAL** _____

**RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INS BENEFITS**: I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician on my behalf. I authorize Central Indiana Pain Management to obtain medical information for the purpose of referrals.

**PLEASE INITIAL** _____

*Complete this area only if you have Medicare coverage*

**MEDICARE CERTIFICATION**: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician who treats me to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

**PLEASE INITIAL** _____

**ADVANCED DIRECTIVE**

1. Do you have a living will? Y or N
   If you answered yes, we may need a copy for your chart. A copy was received by this office _____
2. Have you given anyone your Power of Attorney? Y or N Please list name_____
   If you answered yes, we may need a copy for your chart. A copy was received by this office_____
3. **REQUIRED TO BE COMPLETED**: **Please indicate below who you are appointing as your personal representative to receive medical information. If you choose to indicate NONE, please do so on the first line.**

I give my consent and authorization for this person or persons listed below to act as my personal representative and to receive any and all information from my medical records, or discuss any and all aspects of my medical care. I also give consent and authorization for the person or persons to be notified any time I have an appointment. I also understand that I may revoke this privilege at any time by submitting my request in writing to this office.

Name of your Personal Representative_____Relationship_____

Name of your Personal Representative_____Relationship_____

Name of your Personal Representative_____Relationship_____

Name of your Personal Representative_____Relationship_____

**Patient Signature** _____**Date**_____

# HIPPA PRIVACY ACKNOWLEDGEMENT

I have been offered a copy of the privacy policy from Medical Pain & Spine Care of Indiana (MPSCI).

_____ _____

**Patient Signature** **Date**

I authorize MPSCI to discuss information regarding my medical treatment with:

Spouse _____

Children _____

Parent(s) _____

Other(s) _____

None _____

I give my consent and authorization for the medical or billing staff of MPSCI to leave protected health care information about me or for me on my answering machine or voice mail via the telephone at the number I have provided. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

_____ _____

**Patient Signature** **Date**

## MEDICATION DISCLAIMER

As a patient of Dr. Klim's, I realize my responsibility to notify the physician and/or nurse of <u>all</u> the medicines, including herbal, over-the-counter, and as need medications that I am currently taking with all office and hospital visits. **This list is complete to the best of my knowledge**. I will contact the office if I have any questions regarding my medications.

_____ _____

**Patient Signature** **Date**

# FINANCIAL POLICY

Thank you for choosing Medical Pain and Spine Care of Indiana (MPSCI) and Dr. Peter Klim as your health care provider!

We are committed to providing you with quality health care. Please read our policies below and ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in many insurance plans including some types of Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but do not have an up to date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles**. All co- payments and deductibles must be paid at the time of service. This is part of your contract with your insurance company. Failure on our part to collect co-pays and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services**. Please be aware that some – and perhaps all (tangible and non-tangible) – of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of Insurance**. All patients must complete our patient information before seeing the doctor. We must obtain a copy of your current valid insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will be billed to you.
7. **Nonpayment**. If your account is more than 90 days past due, you will receive a letter stating that you have 14 days to pay your payment in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. The agency will bill you for the amount and any court costs up to $250. If your account is sent to collections you and your immediate family have 30 days to find alternative care. During that 30-day period, our physicians will only be able to treat you and your family on an emergency basis.
8. **Missed appointments**. We reserve the right to charge patients and discharge them from the practice if missed appointments are not canceled within 24 hours before the scheduled visit. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointments.
9. **Forms**. There is a charge for all forms requiring a physician and/or medical staff person to complete. Fees will need to be paid prior to the forms being completed.

**I have read and understand the financial policy and agree to abide by it's guidelines. I consent to treatment by, and authorize insurance benefits to be paid directly to Medical Pain & Spine Care of Indiana. I agree that I am responsible to pay 1) for services not covered by my insurance company 2) co-payments and deductibles 3) any expense associated with the collection of a debt owed to them by me (e.g. attorney fees, court costs or collection agency fee). I also consent to the release of pertinent medical information to my insurance carrier for the purpose of processing health care claims.**

_____ _____

**Patient Signature** **Date**

# PATIENT HEALTH HISTORY

**Patient _____ Date of Birth: _____**

**Pharmacy Name, City_____**

**ARE YOU ALLERGIC TO ANY MEDICATION? ____ Yes ____ No.** If yes, please list below:

| Name of Medication | Type of Reaction |
|---|---|
| | |
| | |
| | |

**PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:**

| Name of Medication | Dosage | How Often Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**PLEASE LIST ANY MEDICATIONS YOU HAVE TRIED IN THE PAST FOR PAIN(not currently taking):**

| Name of Medication | Dosage | Did it help your pain? Y or N |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**SURGERIES AND HOSPITALIZATIONS.**

Have you ever had any problems with anesthesia (being put to sleep)? ____Yes ____No

List any surgeries you have had (including dates):

Appendectomy _____Year
Back Surgery _____Lower _____ Neck _____ Year
Breast biopsy _____ Lt ____ Rt _____ Year
Breast, lumpectomy _____ Lt _____ Rt _____ Year
Breast, mastectomy _____ Lt ____Rt _____ Year
Cataract Surgery ___Lt ____Rt _____ Year
Coronary artery heart bypass _____Year
Gallbladder _____Year
Hernia, ___Lt ____Rt ____ Umbilical _____ Year
Hysterectomy ___ laparoscopic ___
Hysterectomy, with removal ____Lt Ovary ____Rt Ovary
Knee Surgery, ____ Lt ____ Rt _____Year
Tonsillectomy _____Year
Vaginal _____Year

Other Surgery - Please fill in details: _____
_____ _____
_____ _____

_____ _____

**Patient Signature** **Date**

# PATIENT HEALTH HISTORY (continued)

**Review of Systems**

| **Constitutional** | | | **Musculoskeletal** | | |
|---|---|---|---|---|---|
| Recent Weight Gain | No | Yes | Limitation of any joint, including back | No | Yes |
| Recent Weight Loss | No | Yes | Loss of muscle strength | No | Yes |
| Fever | No | Yes | Muscle pain | No | Yes |
| Fatigue | No | Yes | Pain in neck | No | Yes |
| Insomnia | No | Yes | Pain in back | No | Yes |
| **Ears/Nose/Throat** | | | Pain in joints | No | Yes |
| Hearing loss | No | Yes | **Integumentary** | | |
| Ringing in ears | No | Yes | Bruises easily | No | Yes |
| Nosebleeds | No | Yes | Moles that have changed | No | Yes |
| Bleeding gums | No | Yes | Skin lesions | No | Yes |
| Sore throat | No | Yes | Skin rash | No | Yes |
| **Cardiovascular** | | | **Neurological** | | |
| Abnormal heart rhythm | No | Yes | Difficulty with balance | No | Yes |
| Chest pain | No | Yes | Drooping on one side of face | No | Yes |
| Palpitations | No | Yes | Headache | No | Yes |
| Swelling in ankles | No | Yes | Loss of bowel control | No | Yes |
| **Respiratory** | | | Loss of bladder control | No | Yes |
| Cough | No | Yes | Seizures | No | Yes |
| Short of breath | No | Yes | Tingling, “Pins and needles” sensation | No | Yes |
| Wheezing | No | Yes | Paralysis | No | Yes |
| **Gastrointestinal** | | | **Psychological** | | |
| Abdominal Pain | No | Yes | Anxiety | No | Yes |
| Blood in stool | No | Yes | Depression | No | Yes |
| Constipation | No | Yes | Hear or see things other do not | No | Yes |
| Nausea | No | Yes | Suicidal thoughts | No | Yes |
| Heartburn | No | Yes | Violent thoughts | No | Yes |
| Swallowing problems | No | Yes | **Hematologic/ Lymphatic** | | |
| Vomiting | No | Yes | Masses in armpit | No | Yes |
| **Genitourinary** | | | Masses in groin | No | Yes |
| Frequent urination | No | Yes | Masses in neck | No | Yes |
| Dialysis | No | Yes | Masses in other areas | No | Yes |

**Medical History**

| | | | | | |
|---|---|---|---|---|---|
| Ascites (fluid in abdomen) | No | Yes | High Blood Pressure | No | Yes |
| Asthma | No | Yes | HIV | No | Yes |
| Bleeding Disorder | No | Yes | Kidney Failure | No | Yes |
| Cancer | No | Yes | Kidney Stones | No | Yes |
| (type _____) | | | Liver Disease | No | Yes |
| Congestive Heart Failure | No | Yes | Migraines | No | Yes |
| Coronary Artery Disease | No | Yes | Pancreatitis | No | Yes |
| Depression | No | Yes | Peripheral Vascular Disease | No | Yes |
| Diabetes | No | Yes | Rheumatic Fever | No | Yes |
| Emphysema or COPD | No | Yes | Seizures | No | Yes |
| Endometriosis | No | Yes | Sleep Apnea | No | Yes |
| Gallstones | No | Yes | Stomach Ulcers | No | Yes |
| Heart Arrhythmia | No | Yes | Stroke/ TIA | No | Yes |
| Heart Attack | No | Yes | Thyroid Disease | No | Yes |
| Hepatitis | No | Yes | Heart Valve Disease | No | Yes |

_____ _____

**Patient Signature** **Date**

# PATIENT HEALTH HISTORY (continued)

**Do you currently take any BLOOD THINNERS** (Coumadin, Eliquis, Plavix, Pradaxa, Warfarin, etc ) ?

If Yes, which one : _____

(FEMALE PATIENTS ) Is there a chance you a pregnant now ? No Yes

**Family Medical History** If YES, please list the relative and age diagnosed

| | | |
|---|---|---|
| Colon Cancer | No Yes | _____ |
| Colon Polyps | No Yes | _____ |
| Inflammatory Bowel Disease | No Yes | _____ |
| Cancer of: | | |
| Endometrial | No Yes | _____ |
| Esophagus | No Yes | _____ |
| Kidney | No Yes | _____ |
| Lung | No Yes | _____ |
| Ovarian | No Yes | _____ |
| Pancreas | No Yes | _____ |
| Other type: | No Yes | _____ |

**Social History**

Marital Status: Single ____ Married ____ Divorced ____ Widowed _____

Children: No ____ Yes ____

Use of **Alcohol**: No ____ Yes ____ Use of **Tobacco**: No ____ Yes ____

History of substance abuse, misuse of prescribed medications : No ____ Yes ____

Do you live alone ? No ____ Yes ____ _____

Work Status: Work full time ____ Work part time ____ Unemployed ____

Disabled: No ____ Yes ____ Reason _____

Do you handle your daily needs by yourself (bathing, cooking, dressing, shopping, etc.)

No ____ Yes ____

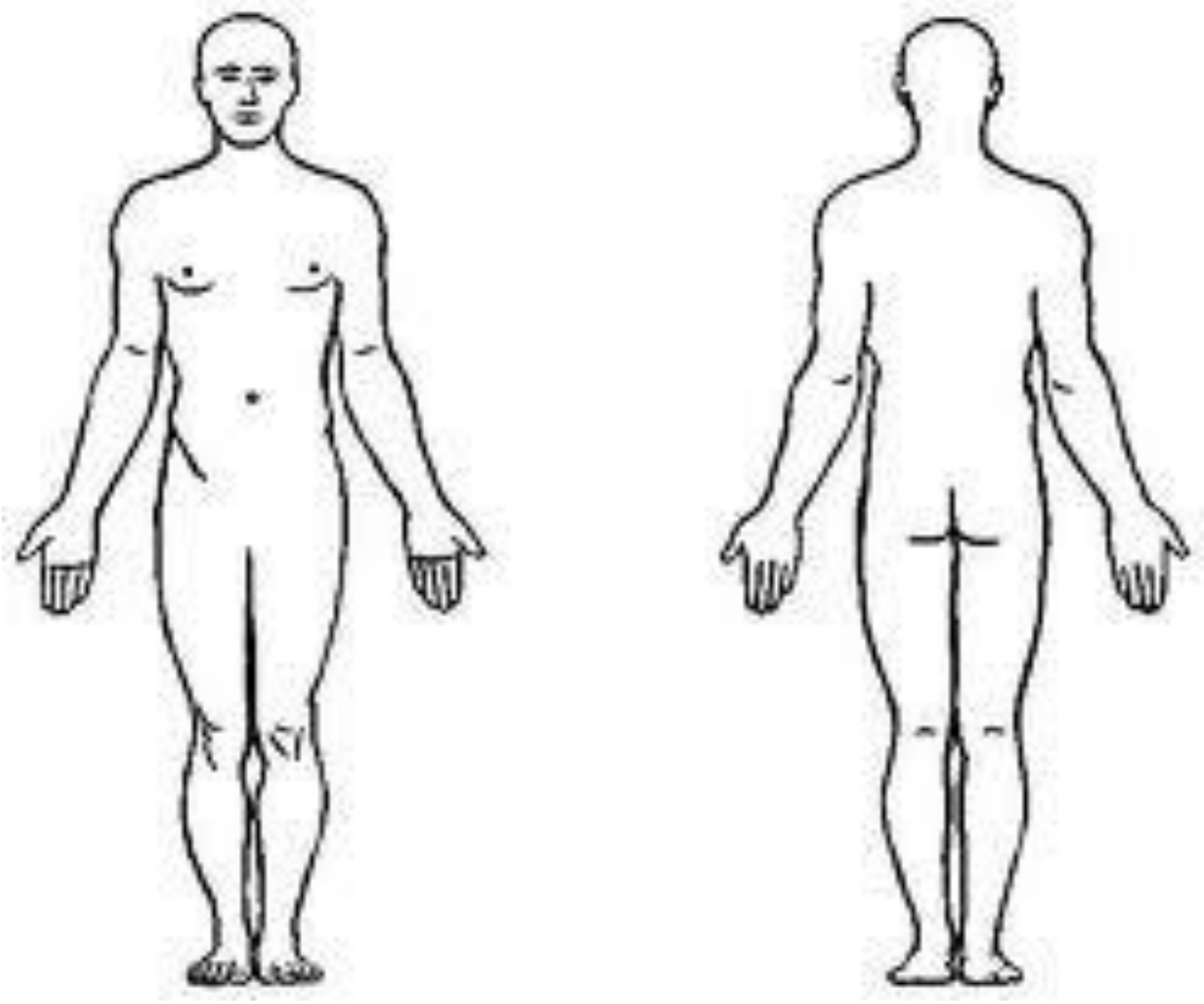
**Authorization & Release**

To the best of my knowledge, I have answered the questions on these forms accurately. I understand that providing inaccurate information can be dangerous to my health. I understand that it is my responsibility to inform my healthcare providers of any change in my medical status. I authorize the healthcare staff to perform the necessary services I may need and release information to others if necessary for my care.

_____ _____

**Patient Signature** **Date**

# PAIN DIAGRAM



Please mark the areas affected by pain on the figure above.

_____ _____

**Patient Signature** **Date**

Reviewer Initials_____

# HISTORY of PRESENT ILLNESS

What is the chief complaint that brings you to the doctor today? _____
_____ ___
When did you first start experiencing your pain symptoms? MM/DD/YY _____ _____
What activity/ factors make your pain better: _____
What activity/ factors make your pain worse: _____
Pain severity: mild moderate severe
Pain Quality: dull aching stabbing cramping shooting burning throbbing
Pain Duration: Intermittent (stops & starts) or Persistent (all the time) Pain worse in: morning afternoon evening
Have you had Physical Therapy IN THE PAST 12 MONTHS ? No/ Yes If Yes, where: _____
Have you tried heat, cold or rest to control your pain ? _____
Have you ever been to another Pain Center? No/ Yes If Yes, where/when: _____
Other past pain treatments: Spinal cord stimulation DRG stimulation
Other past failed treatments: _____

Please identify which of the following medications **you have tried** in the past by checking the appropriate box.

| | HELPFUL ? | | | HELPFUL ? | | | HELPFUL ? | |
|---|---|---|---|---|---|---|---|---|
| **NSAID** | Y | N | **MUSCLE RELAXANT** | Y | N | **ANTICONVULSANT** | Y | N |
| Ibuprofen | | | Baclofen | | | Tegretol | | |
| Indocin | | | Flexeril | | | Lamictal | | |
| Lodine | | | Norflex | | | Depakote | | |
| Relafen | | | Robaxin | | | Neurontin/Gabapentin | | |
| Motrin | | | Skelaxin | | | Topamax | | |
| Naprosyn | | | Soma | | | Lyrica | | |
| Mobic | | | Valium | | | Dilantin | | |
| Celebrex | | | Xanaflex | | | | | |
| **OPIOID** | | | **OTHERS** | | | **ANTIDEPRESSANT** | | |
| Darvocet | | | | | | Elavil | | |
| Percocet | | | Talwin | | | Doxepin | | |
| Lortab/ Norco | | | Fioricet | | | Cymbalta | | |
| Duragesic | | | Ultram | | | Effexor | | |
| Dilaudid | | | Lidoderm | | | Zoloft | | |
| Oxycontin | | | Imitrex | | | Zyprexa | | |
| MS Contin | | | Amerge | | | Wellbutrin | | |
| MS IR | | | Steroids | | | Prozac | | |
| Kadian | | | Suboxone | | | Serzone | | |
| Levorphanol | | | Dextromethorphan | | | Pamelor | | |
| Methadone | | | Stadol | | | | | |
| Actiq | | | | | | | | |
| Opana | | | | | | | | |

_____ _____

**Patient Signature** **Date**

## ORT

**Please check the corresponding answer** to the right of the questions below.

| | | |
|---|---|---|
| Are you between 16 and 45 years old? (1) | YES [ ] | NO [ ] |
| Have you been diagnosed with a psychological disorder? (2)<br>Example: ADHD, OCD, Bipolar, Schizophrenia | YES [ ] | NO [ ] |
| Do you currently suffer from depression? (1) | YES [ ] | NO [ ] |

Do you have a **personal history** of abuse of any of the following?

| | | |
|---|---|---|
| Alcohol Abuse (3) | YES [ ] | NO [ ] |
| Illegal Drug Use (4) | YES [ ] | NO [ ] |
| Prescription Drug Abuse (5) | YES [ ] | NO [ ] |

Does anyone **in your family** have a history of abuse of any of the following?

| | | |
|---|---|---|
| Prescription Drug Abuse (4) | YES [ ] | NO [ ] |
| Alcohol Abuse (3,1) | YES [ ] | NO [ ] |
| Illegal Drug Use (3,2) | YES [ ] | NO [ ] |
| Do you have a history of preadolescent sexual abuse? (0,3) | YES [ ] | NO [ ] |

## PHQ- 4

Over the **last 2 weeks**, circle how often have you been bothered by the following problems?

| | Not at all | Several days | More than half | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious or on edge. | 0 | 1 | 2 | 3 |
| 2. Not being able to stop control worrying. | 0 | 1 | 2 | 3 |
| 3. Little interest or pleasure in doing things. | 0 | 1 | 2 | 3 |
| 4. Feeling down, depressed or hopeless. | 0 | 1 | 2 | 3 |

_____ _____

**Patient Signature** **Date**

# BRIEF PAIN INVENTORY (SF)

Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pan today?

Yes No

Please rate your pain by marking the box beside the number that best describes your pain at its **worst** in the last 24 hours.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | | | | | | | | | | Pain as Bad As You Can Imagine |

Please rate your pain by marking the box beside the number that best describes your pain at its **best** in the last 24 hours.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | | | | | | | | | | Pain as Bad As You Can Imagine |

Please rate your pain by marking the box beside the number that best describes your pain **on average**.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | | | | | | | | | | Pain as Bad As You Can Imagine |

Please rate your pain by marking the box beside the number that tell how much pain you have **right now**.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | | | | | | | | | | Pain as Bad As You Can Imagine |

In the last 24 hours, how much pain relief have pain treatments or medications provided? Please mark the box below that most shows how much relief you have received.

| 0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |
|---|---|---|---|---|---|---|---|---|---|---|
| No Relief | | | | | | | | | | Complete Relief |

Mark the box beside the number that describes how, during the past 24 hours, pain has interfered with your:

**General Activity**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does Not Interfere | | | | | | | | | | Completely Interferes |

**Mood**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does Not Interfere | | | | | | | | | | Completely Interferes |

**Walking Ability**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does Not Interfere | | | | | | | | | | Completely Interferes |

**Normal Work (includes both work outside the home and housework)**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does Not Interfere | | | | | | | | | | Completely Interferes |

# BRIEF PAIN INVENTORY (SF) COTINUED

Mark the box beside the number that describes how, during the past 24 hours, pain has interfered with your:

**Relations with other people**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does Not Interfere | | | | | | | | | | Completely Interferes |

**Sleep**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does Not Interfere | | | | | | | | | | Completely Interferes |

**Enjoyment of life**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Does Not Interfere | | | | | | | | | | Completely Interferes |

# Patient Consent Form for Use of Long-Term Opioid Medications for Chronic Pain

I understand that Medical Pain and Spine Care of Indiana (MPSCI) is providing this Patient Information to help my doctor and me work together toward safe and effective medical care and management of my pain condition and to prevent problems with my pain management medicine. I understand that my doctor must comply with legal requirements for prescribing opioids, and that these requirements, may, on occasion, limit or even prevent my doctor from prescribing opioids to me.

**WHAT IS THE GOAL OF OPIOID THERAPY?**

The goal is to increase functionality (help me do everyday activities) and to ***reduce*** my pain. ***I know that opioids will not cure my pain***. They also have major risks and side effects. That is why it is important for my doctor and me to carefully monitor my use of opioids to see if they are the right medicine for me. I understand that opioids work best when I also use self-care skills and follow my chronic pain care plan.

**WHAT DO I NEED TO KNOW ABOUT OPIOIDS?**

I understand that the long-term advantages and disadvantages of chronic opioid therapy have yet to be scientifically determined and that treatment may change throughout my time as a patient. I understand, except, and agree that there may be unknown risks associated with the long-term use of these controlled substances in my doctor will advise me as knowledge and training advance and we'll make appropriate treatment changes.

**Opioids may cause physical dependence:** Using any opioid daily for more than a few weeks causes PHYSICAL DEPENDENCE. This means that within a few days of quickly reducing my opioid dose, I may feel sick from withdrawal symptoms. These include: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, body aches and/or a flu-like feeling. These symptoms may last seven to ten days or longer but they are rarely life threatening. This is NOT addiction.

**Opioids may cause tolerance:** Over time some people may acquire a tolerance to opioids. TOLERANCE means that the same dose of opioid gives less pain relief. TOLERANCE is not the same as addiction. After an initial dose adjustment time period, most people with chronic pain do not acquire major tolerance to opioid pain relief but I might. If I do, a higher dose may not always help my pain and may actually increase my pain and other side effects. Tolerance like this to opioids means that I should not continue to take them. Nicotine use causes opioid tolerance and craving.

**Opioids may cause addiction**. Addiction is the use, craving or psychological need of a drug despite harm to quality of life, health or social relations. The risk for most people is low but I may be more vulnerable if I have a family or personal history of addiction. My risk of addiction is also higher if I use nicotine products (cigarettes, snuff, chew, etc.); or if I have a history of certain mental health issues. I know that if I have any of these risk factors, my providers and I will need to watch more carefully for addiction symptoms. My chronic pain care plan may then include consultation with an addiction specialist or program.

**The response to opioids varies**: Some people do not respond well to opioids. ***My doctor has a professional and legal obligation to stop prescribing opioids to me if using them does not reduce my pain and improve my ability to function.*** My doctor will most often prescribe a tapering amount of medicine to reduce withdrawal symptoms. Other medicines can also help reduce opioid withdrawal symptoms.

_____ _____

**Patient Signature** **Date**

# (Patient Consent Form for Use of Long-Term Opioid Medications For Chronic Pain continued)

**Long-term opioid use can affect hormone levels**. This may affect my mood, strength, sexual desire and physical and sexual performance. In men, this may lower testosterone levels. In women, this may affect periods. In both women and men, fertility may be impaired.

**(Women Only)** I will tell my doctor right away if I plan to become pregnant or think I may have become pregnant while taking opioids. I am aware that use of opioids during pregnancy may lead to serious birth defects. I am also aware that if I give birth while taking opioids, the baby may temporarily be physically dependent upon opioids.

**I will remember that non-drug treatments will likely improve how well I function and help reduce my pain more than opioid medicine in the long run.**

**What are the reasons my doctor may stop prescribing my opioids?**

- My doctor may decide to stop prescribing opioids for me if they no longer control my pain or improve my function and quality of life.
- I understand that if I fail to fully follow my doctor's advice, it may be a sign that my use of opioids is no longer safe and helpful.
- My doctor may also stop prescribing opioids for these reasons:
  - I become tolerant to opioids (the same dose of opioids gives less pain relief)
  - I have major side effects
- My doctor may taper me off opioids if I frequently request an increase in the dose or how often I take my opioids as this may mean my pain is no longer responding to opioids.
- My doctor may taper me off opioid medicines for missing opioid refill appointments, frequent rescheduling, or often being late for appointments. I recognize that all of these behaviors may be signs of opioid dependency.
- If I fail to follow the non-opioid parts of my therapy, my doctor may stop my opioid medicines.
- Violent or disrespectful behavior or threats to staff or other patients are grounds for stopping my treatment with opioids. My doctor may report my actions to the local law enforcement agency. If there are safety concerns for other patients or staff my doctor may not taper the medications, but stop opioids immediately.

**PATIENT ACKNOWLEDGEMENT OF RECEIPT AND UNDERSTANDING OF INFORMATION CONCERNING LONG-TERM OPIOID MEDICATIONS**

_____ _____

**Patient Signature** **Date**

# OPIOID MEDICATION AGREEMENT

Before Medical Pain and Spine Care of Indiana (MPSCI) considers prescribing any opioid medications for your pain, you will need to be aware and familiar with the program's guidelines and regulations pertaining to these medications, and agree to follow them at all times. This Agreement must be read and signed before any opioid medications may be dispensed. It contains important information pertinent to the use of opioids. **Please take the time to carefully read this document**.

1. Opioid medications may be prescribed for me ONLY by Dr. Peter Klim or MPSCI clinicians. I will not get opioid prescriptions or opioid medicines (including tramadol, hydrocodone, oxycodone, morphine, fentanyl, methadone, hydromorphone, oxymorphone, etc) from any other source, including borrowing from family or friends.
2. I will not solicit nor accept a prescription for opioid medication from any other physician without the prior written consent of Dr. Peter Klim.

3. I will use only one pharmacy to fill and/or refill ALL my opioid medications unless otherwise directed by Dr. Klim.
4. I agree to provide and maintain a working contact phone number at which I may be reached at any time. I will notify MPSCI of any changes to contact information within 24 hours of such change. I further acknowledge that if MPSCI is unable to reach me using the contact information I provided, I may be dismissed from MPSCI.
5. I will take my opioids only at the dose and frequency as prescribed by Dr. Klim. I will NOT increase my dose or frequency without my doctor's permission. I understand that my pain medicine **prescriptions are written to last until my next scheduled office visit; early refills will not be given**.

6. I know that requesting more opioids or higher doses, or taking opioids more often than prescribed, may be a sign that my chronic pain is not responding to opioids and my doctor may need to taper me off opioids.
7. I understand that taking more than the amount prescribed or combining opioids with other drugs can cause symptoms of overdose **or death**. I will call 911 or my local poison control center if I think I have taken an overdose.
8. I agree that when MPSCI asks I will provide a body fluid sample for drug testing, as the physician licensing agencies recommend, to confirm that I am keeping this agreement. I will not use any illegal or illicit (unauthorized) drugs and understand that combining these drugs with opioids can result in dangerous side effects **including death**. Illegal drug use is strictly prohibited and may result in dismissal from MPSCI.
9. I will not share, sell, or trade my medicine with anyone as this violates federal law.

10. I will avoid driving, using heavy machinery or doing anything that requires me to be alert for 4-5 days after beginning opioid treatment or after a change in opioid treatment such as a dose increase. The final decision on whether you should drive while using opioid medications is a legal issue and should be addressed with your automobile insurance carrier.
11. I will NOT USE alcohol when using pain medicine since this may impair my driving, operating machinery or doing any activity that requires me to be alert and cause other serious health risks.

12. I understand that opioid medication prescriptions will be issued only in the clinic during a scheduled office visit. **No prescriptions will be 'called in', faxed, or mailed**. This is done for the purpose of maintaining adequate control and documentation on the distribution of these controlled substances.

**Patient Initials**_____

# OPIOID MEDICATION AGREEMENT (continued)

13. If I experience a problem with my medication (side-effect), I will stop taking it immediately and contact the prescriber of the medication. If the side-effect seems serious, I will go to the nearest emergency room. If the side-effect is simply that I do not tolerate the medication well, I will stop taking it and call the prescriber of the medication to request an appointment to discuss the problem. **I understand that medication changes are not done over the phone and if I need medication doses changes I will need to make an appointment**.
14. I acknowledge that an opioid prescription for any longer than 4 weeks is purely at the discretion of Medical pain and Spine Care of Indiana (MPSCI) clinicians. I acknowledge that Mail-in Prescription Service Programs and 90 day supplies of opioids may be inappropriate and/or unsafe for me, and my MPSCI clinician may not provide such a supply.
15. I will keep my opioids in a safe place to prevent theft and where children or pets cannot get to them (a locked box is best). I will avoid packing opioids in checked luggage. I understand that **lost, damaged, destroyed, or stolen medicines will not be replaced**.
16. I know that an important part of my pain management program may include non-drug treatment, including, but not limited to: physical therapy, interventional pain management injections, pain management device implants, use of back braces or other durable medical equipment, and behavioral counseling. If I fail to follow through with the entire treatment plan recommended by Dr. Klim or his associates for my chronic pain, I understand and agree that opioids may be withdrawn.
17. **I will not undergo any pain management procedures or injections from other physicians without the prior consent of Dr. Klim or his associates**. I am free to transfer my interventional care at any time; MPSCI would expect those physicians to assume continued prescribing of all opioid medications.
18. I agree to be evaluated by a psychologist and/or addiction specialist at any time during my treatment at my doctors' request. If in their opinion I am not a candidate for further opioid treatment, I agree to weaning and treatment discontinuation.
19. For female patients, I understand that if I continue taking opioid medications during my pregnancy, my baby will be at risk for **opioid dependency** and **neonatal abstinence syndrome. I will inform my pain medicine doctor/nurse if I think I am pregnant.**

20. I understand that improvement in my quality of life and functional capabilities, as well as a reduction in the intensity of my pain, are the desired goals of treatment. Opioid medications are not intended to 'cure' all of my pain. If my care provider at determines, in his or her professional medical opinion, that these objectives are not being met with the use of opioids, I agree to weaning and/or discontinuation of opioid medication.

**This agreement will continue in effect as long as MPSCI prescribes my opioid medications. Continued filling of these prescriptions confirms my acceptance of all parts of this agreement.**

**PATIENT'S APPROVAL OF THE LONG-TERM OPIOID MEDICATIONS AGREEMENT:**

I have read the information and have had a chance to ask for more information about this therapy. I am satisfied with the information I have received. I have no further questions. I understand that my physician may discontinue prescribing opioids at any time. I understand that my failure to comply with **all** parts of this agreement may cause my physician to decide that continued use of opioids is no longer safe and effective and to stop prescribing them.

_____ _____

**Patient Signature** **Date**

# CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours' notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours' notice, we are unable to offer that slot to other people. Office appointments which are cancelled with less than 24 hours notification may be subject to a $25.00 cancellation fee. Procedure cancellations require 5-7 business day advance notice, without notification they may be subject to a $100.00 cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as NO SHOW. Patients who No-Show two (2) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments. Patients may also be subject to a $20.00 fee for office appointment No Show and $100.00 procedure No Show fee.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department (765/472-2085).

Please sign that you have read understand and agree to this Cancellation and No show Policy.

_____ _____

Patient Name (Please Print) Date of birth

_____ _____

Signature of Patient or Patient Representative Today's Date

# Consent to Email and/or Text Message for Appointment Reminders And Other Healthcare Communications

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders and or information.

I consent to receiving appointment reminders and other healthcare communications, information at that email and or text from Medical Pain and Spine Care of Indiana.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number. The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is (___) ____ -____

Carrier: _____

_____ (Patient initials) I consent to emails, to receive communications as stated above.

The email that I authorize to receive email messages for appointment reminders and general health

Reminders/feedback/information is _____.

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

_____ _____

**Patient Signature** **Date**