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 all 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

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 HISTORY FORM

Date: _______/_________/________

NAME: ____ Birthdate: _____/______/_____

Last First M. I.

Age:___________ Sex: ❑ F ❑ M

How did you hear about this clinic?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

Psychiatric Hospitalizations (include where, when, & for what reason):

Have you ever had ECT? Have you had psychotherapy?

CURRENT MEDICATIONS		
Drug allergies: ❑ No ❑ Yes To Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:		
Name of drug	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**
1.		
2.		

3.
4.
5.
LIST ANY OTHER MEDICATIONS YOU TAKE
6.
7.
8.
9.
10.

Do you have a primary care doctor? ____

Did you have any blood work in the past 3 months? ____

Have you ever used IV drugs? ____

Have you been tested for HIV/ Hepatits/ Other ____

Do you drink Alcohol? ___________________________________

How many drinks per day/ week? ________________________

Do you smoke cigarettes? _____________________________________

How many per day? ____

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) ___________________
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

PERSONAL HISTORY

Were there problems with your birth? (specify)

Where were your born & raised?

What is your highest education? ❑High school ❑Some college ❑College graduate ❑Advanced degree

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

What is your current or past occupation?

Are you currently working? : ❑ Yes ❑ Hours/week If not, are you ❑ retired ❑ disabled ❑ sick

No ______ leave?

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability & how long?___________________________

Have you ever had legal problems? (specify)

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:

Maternal Relatives:

Paternal Relatives:

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL

❑ Recent weight gain; how much____

❑ Recent weight loss: how much____

❑ Fatigue

❑ Weakness

❑ Fever

❑ Night sweats

MUSCLE/JOINTS/BONES

❑ Numbness

❑ Joint pain

❑ Muscle weakness

❑ Joint swelling

Where?

EARS

❑ Ringing in ears

❑ Loss of hearing

EYES

❑ Pain

❑ Redness

❑ Loss of vision

❑ Double or blurred vision

❑ Dryness

NERVOUS SYSTEM

❑ Headaches

❑ Dizziness

❑ Fainting or loss of consciousness

❑ Numbness or tingling

❑ Memory loss

STOMACH AND INTESTINES

❑ Nausea

❑ Heartburn

❑ Stomach pain

❑ Vomiting

❑ Yellow jaundice

❑ Increasing constipation

❑ Persistent diarrhea

❑ Blood in stools

❑ Black stools

SKIN

❑ Redness

❑ Rash

❑ Nodules/bumps

❑ Hair loss

❑ Color changes of hands or feet

PSYCHIATRIC

❑ Depression

❑ Excessive worries

❑ Difficulty falling asleep

❑ Difficulty staying asleep

❑ Difficulties with sexual arousal

❑ Poor appetite

❑ Food cravings

❑ Frequent crying

❑ Sensitivity

❑ Thoughts of suicide / attempts

❑ Stress

❑ Irritability

❑ Poor concentration

❑ Racing thoughts

❑ Hallucinations

❑ Rapid speech

❑ Guilty thoughts

❑ Paranoia

❑ Mood swings

❑ Anxiety

❑ Risky behavior

OTHER PROBLEMS:

THROAT

- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS

- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

BLOOD

- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER

- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:

- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

WOMENS REPRODUCTIVE HISTORY:

Age of first period:

Pregnancies:

Miscarriages:

Abortions:

Are you presently sexually active? Y / N

Do you think you may be pregnant now? Y / N

Have you reached menopause? Y / N At what age?

Do you have regular periods? Y / N

SUBSTANCE USE HISTORY					
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes □ No □
CANNABIS: Marijuana, hashish, hash oil					Yes □ No □
STIMULANTS: Cocaine, crack					Yes □ No □
STIMULANTS: Methamphetamine—speed, ice, crank					Yes □ No □
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes □ No □
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, “Roofies”					Yes □ No □
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes □ No □
HEROIN					Yes □ No □
STREET OR ILLICIT METHADONE					Yes □ No □
OTHER OPIOIDS: Tylenol #2 & #3, 282’S, 292’S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes □ No □
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes □ No □
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes □ No □
OTHER: specify)______________________________ ____________________________________ ____________________________________ __________					Yes □ No □

Patient Agreement to Participate in Medically Assisted Treatment (MAT)

As a participant in Dr. Klim's MAT treatment program for opioid abuse and dependence, I freely and voluntarily agree to accept this treatment agreement as follows:

1. I agree to keep, and be on time to, all my scheduled appointments with the doctor and treatment nurse practitioner. If I am delayed or I must reschedule my appointment, I will contact my doctor's office within 24 hours of my scheduled appointment or be billed a $25 "no-show" fee. ______

2. I will report my history and symptoms honestly to Dr. Klim and his staff. I will inform Dr. Klim and his staff of my other entire doctor and dentist appointments, and any medications (prescription or non-prescription) that I am taking. I will report any change in my medical history, such as becoming pregnant or developing hepatitis C. _____

3. I understand that buprenorphine/naloxone combination medications have the same addictive properties as opiates such as heroin, methadone, codeine, morphine and OxyContin. Stopping buprenorphine/naloxone combination medications suddenly will result in the same withdrawal symptoms and put me at the same risk of relapse as with opiates. ______

4. I agree to provide urine for the purpose of toxicology screens at any time during my treatment. The results of these tests will be used to assist me in my recovery goals._____

5. I will tell Dr. Klim and his staff if I have used alcohol or street drugs before a drug test result shows it.____

6. I agree that my medication prescription can be given to me only at my office visits and only by the doctor. If I miss scheduled office visits, I may not be able to get a prescription until the next scheduled visit. _____

7. I understand that if I do not participate in the recommended behavioral health counseling and do not provide my doctor's office with official proof of behavioral health counseling, my medical insurance **may not pay for my medication**. _____

8. I agree that authorizations for my medication will be processed during regular office hours and NOT AFTER HOURS OR ON WEEKENDS. ____

9. I agree to take my medication as the doctor has instructed and not to alter the way I take my medication. ______

10. I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place, away from children, pets or any person who could potentially abuse it. I understand that lost, stolen or damaged medication will not be replaced. _______

11. I understand that if I run out of my medication before it is time for a refill I could end up experiencing symptoms of opiate withdrawal. _____

12. I agree not to sell, share, or give any of my medication to another individual. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated. _____

13. **I agree not to obtain any medications from any physicians, pharmacies, or other sources without informing my treating physician. I understand that mixing buprenorphine (Suboxone, Subutex, Zubsolv, Bunavail, etc) with other medications, especially benzodiazepines (Xanax, Ativan, Valium, Klonopin, etc), alcohol or other drugs of abuse, can be dangerous. I also understand that a number of deaths have been reported among individuals mixing buprenorphine with benzodiazepines. _______**

Patient Agreement to Participate in Medically Assisted Treatment (MAT) Continued

14. I understand that medication alone is not sufficient treatment for my addiction, and I agree to participate in creating and carrying out a recovery treatment plan. This plan will be revised, with my input and as needed, to assist me in my recovery. The treatment plan will include patient education, referrals to relapse prevention programs and active involvement with those programs. ______

15. I agree that medication management of addiction with buprenorphine medications (Suboxone, Zubsolv, etc), is only one part of the treatment of my addiction, and I agree to participate in a regular program of professional counseling as recommended by my doctor's office for as long as my doctor recommends. _____

17. I agree that the support of loved ones is an important part of recovery, and I agree to invite significant persons in my life to participate in my treatment. _____

18. I agree that if my doctor determines that treatment is not benefitting me my treatment at Dr. Klim's office may be discontinued. If this happens I will be given information about other treatment centers in my area. _____

19. I understand and acknowledge that it is my responsibility to provide proof of monthly counseling to Dr. Klim's office on official letterhead from my counselor's office at least once every four weeks. _____

20. I understand and acknowledge that if I do not provide proof of counseling my medical insurance plan may not pay for my medication or treatment.____

21. I understand and acknowledge that if my drug tests demonstrate illegal or unauthorized substance use my medical insurance may not pay for my medication or treatment.____

22. I understand and agree that my medical treatment (medications and office visits) may be discontinued if I do not comply with recommended behavioral health counseling and/ or use unauthorized or illegal substances. ____

23. FOR WOMEN ONLY: I am not pregnant, and I will not have unprotected sex or attempt to become pregnant while taking Suboxone/Zubsolv/Bunavail, because the safety of these medications during pregnancy is unknown. If I accidentally become pregnant I will inform the ASAP team as soon as I am aware so that I can be provided appropriate treatment.

___________________________	_______	_________________	________
Patient (Pt) Printed Name	Pt Initials	Pt Signature	Date

_____________________________	____________
Witness	Date

DAST

1. Have you used drugs other than those required for medical reasons? (Y / N)

2. Have you abused prescription drugs? (Y / N) ___ ___

3. Do you abuse more than one drug at a time? (Y / N) ___ ___

4. Can you get through the week without using drugs (other than those required for medical reasons)? (Y / N) ___ _

5. Are you always able to stop using drugs when you want to? (Y / N) ___ ___

6. Do you abuse drugs on a continuous basis? (Y / N) ___ ___

7. Do you try to limit your drug use to certain situations? (Y / N) ___ ___

8. Have you had “blackouts” or “flashbacks” as a result of drug use? (Y / N) ___ ___

9. Do you ever feel bad about your drug abuse? (Y / N) ___ ___

10. Does your spouse (or parents) ever complain about your involvement with drugs? _(Y / N) __ ___

11. Do your friends or relatives know or suspect you abuse drugs? (Y / N) ___ ___

12. Has drug abuse ever created problems between you and your spouse? (Y / N) ___ ___

13. Has any family member ever sought help for problems related to your drug use? (Y / N) ___ ___

14. Have you ever lost friends because of your use of drugs? (Y / N) ___ ___

15. Have you ever neglected your family or missed work because of your use of drugs? (Y / N) ___ ___

16. Have you ever been in trouble at work because of drug abuse? (Y / N) ___ ___

17. Have you ever lost a job because of drug abuse? (Y / N) ___ ___

18. Have you gotten into fights when under the influence of drugs? (Y / N) ___ ___

19. Have you ever been arrested because of unusual behavior while under the influence of drugs? (Y / N) ___ ___

20. Have you ever been arrested for driving while under the influence of drugs? (Y / N) ___ ___

21. Have you engaged in illegal activities in order to obtain drug? (Y / N) ___ ___

22. Have you ever been arrested for possession of illegal drugs? (Y / N) ___ ___

23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake? (Y / N) ___ ___

24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)? (Y / N) ___ ___

25. Have you ever gone to anyone for help for a drug problem? (Y / N) ___ ___

26. Have you ever been in a hospital for medical problems related to your drug use? (Y / N) ___ ___

27. Have you ever been involved in a treatment program specifically related to drug use? (Y / N) ___ ___

28. Have you been treated as an outpatient for problems related to drug abuse? (Y / N) ___ ___

Patient Signature ______________________________

PHQ-9

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

(Circle the number to indicate your answer)
0 = Not at all 1 = Several days 2 =More than half the days 3 = Nearly every day

1. Little interest or pleasure in doing things 0 1 2 3

2. Feeling down, depressed, or hopeless 0 1 2 3

3. Trouble falling or staying asleep, or sleeping too much 0 1 2 3

4. Feeling tired or having little energy 0 1 2 3

5. Poor appetite or overeating 0 1 2 3

6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down 0 1 2 3

7. Trouble concentrating on things, such as reading the newspaper or watching television 0 1 2 3

8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual 0 1 2 3

9. Thoughts that you would be better off dead or of hurting yourself in some way 0 1 2 3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
Not difficult at all … Somewhat difficult … Very difficult … Extremely difficult

FOR OFFICE CODING 0 + ______ + ______ + ______ =Total Score: ______