METRO SPINE
NON-SURGICAL PAIN INTERVENTION

OXON HILL
6196 Oxon Hill Road, Ste 510
Oxon Hill, MD 20745

CLINTON
9001 Woodyard Road, Ste A
Clinton, MD 20735

UMC
1310 Southern Ave, Ste 202
Washington, DC 20032

OFFICE: 301-856-5860
FAX: 301-856-5864

Welcome and thank you for choosing Metro Spine!

Our mission is to offer you the highest quality of care in a comfortable, efficient and safe manner.

In this packet are included medical and insurance forms, as well as some information and guidelines for your review. Kindly fill out the forms completely and accurately and read the information, which is attached.

Throughout the time you receive services from our office, please feel welcome to contact any member of our team if you have any questions or concerns.

You may also visit our website:

www.treatpainmd.com

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IMPORTANT: Your initial visit today is for an EVALUATION.

This includes review of your medical history, clinical examination and review of medical records and images. Treatment will be determined based on these, and MAY OR MAY NOT include medication.

Metro Spine focuses more on an interdisciplinary approach to pain management in order to achieve better therapeutic outcomes; prescription management is NOT the main focus of our practice.

There is no guarantee that you will be a permanent patient at Metro Spine.

Patient initials: _____

YOUR VISIT AS A NEW PATIENT:

- Check in with the Front Desk. Please have your ID and insurance information ready.
- Kindly fill out the New Patient information packet which will be given to you by the Front Desk staff.
  After completion, immediately hand back the forms.
- Please hand all your medical records, imaging reports and referrals to the Front Desk.
- Wait for your name to be called when it is time for you to be seen.

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CLINICAL INTAKE FORM

PATIENT DEMOGRAPHICS

Please provide your insurance card and valid picture identification.

Your information:		**Today's date:**
Patient Name:		**Date of Birth:**
Address:		
City:	**State:**	**Zip:**
Cell phone:	**SS#:**	**Sexual orientation/Gender identity:** ☐ Male ☐ Female ☐ Transgender ☐ Other ☐ Choose not to disclose
Home phone:	**Work phone:**	
Email:	**Preferred phone** : ☐ Cell ☐ Home ☐ Work	
Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Unknown		
Race/Ethnicity: ☐ American Indian/Alaska Native ☐ Asian/Pacific Islander ☐ Black/African American ☐ White/Caucasion ☐ Hispanic/Latino ☐ Multiracial ☐ Declined ☐ Unavailable		

EMPLOYMENT HISTORY

Employment status: ☐ Employed ☐ Full time ☐ Part time ☐ Self-employed ☐ Not employed ☐ Retired ☐ Student			
Employer:			
Employer Address:	**City:**	**State:**	**Zip:**
Date of Injury/Onset Date:	**Auto Related:** O Yes O No *Ask Front Desk for Auto Accident package*	**Work Related:** O Yes O No	
Claim#:	**Adjustor name:**		
Telephone#:	**Fax:**	**Email:**	
Name of insurance to be billed:			
Attorney name:	**Attorney telephone:**		
Attorney email:	**Attorney Fax:**		

PRIMARY INSURANCE

Insurance Company:	**Phone#:**
Policy/ID #:	**Group#:**
Policy Holder Name:	**Policy Holder Date of Birth:**
Patient's Relationship to Policy Holder: O Self O Spouse O Child O Other	

SECONDARY INSURANCE

Insurance Company:	**Phone#:**
Policy/ID #:	**Group#:**
Policy Holder Name:	**Policy Holder Date of Birth:**
Patient's Relationship to Policy Holder: O Self O Spouse O Child O Other	

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EMERGENCY CONTACT

Contact name:	**Phone #:**
Relationship to Patient: O Parent O Spouse O Child O Sibling O Other	

REFERRING/PRIMARY PHYSICIAN

Physician:	**Phone#:**	**Fax#:**	
Address:	**City:**	**State:**	**Zip:**

PHARMACY INFORMATION

Pharmacy:	**Phone#:**	**Fax#:**	
Address:	**City:**	**State:**	**Zip:**

Financial Policy:

I hereby authorize _____ Insurance Company to pay by ACH, Mail or check directly Metro Spine PC. The medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to this assignee, and I agree to pay in a current manner any balance and said professional service charges above this insurance payment.

If my current policy prohibits direct payment to the physician, then I hereby authorize you to make the payment payable to me and mail to Metro Spine PC. This is a direct assignment of my rights and benefits under this policy.

Thank you for selecting Metro Spine PC as your health care provider. We are committed to provide you with the best possible medical care at the lowest possible cost. Please understand that payment on your bill is considered a part of your treatment. For patients who are responsible for their own coverage we expect full payment for professional services. We accept cash or credit. Under certain circumstances we may be willing to arrange for a payment plan – our practice participates with most insurance carriers. As a courtesy, we will contact your carrier to confirm coverage and estimate their payment for services rendered.

We require you to make payment at the time of service so we do not have to send a bill. Prompt payment allows us to control costs which ultimately keeps our fees to a minimum. Patients with standard co-payment amount per visit should render that payment at the time of service. This payment will be applied to your responsibility part of your policy.

You are responsible to obtain the necessary referral from your primary care provider if it is required by your insurance company.

Return check fees will be added to your balance.

Our staff is available to answer any questions you may have regarding how your claim has been filed with your insurance company.

Please be reminded that your insurance policy is a contract between you and your carrier and in the event of any dispute Metro Spine PC is not a party to that contract and cannot act as a mediator.

I have read and agreed to the above financial policy and its terms and conditions and I certify that the information provided is to the best of my knowledge, true and accurate.

Signature:	**Date:**

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Last name: _____First Name:_____ DOB:___/___/___ Today's date: __/___/___

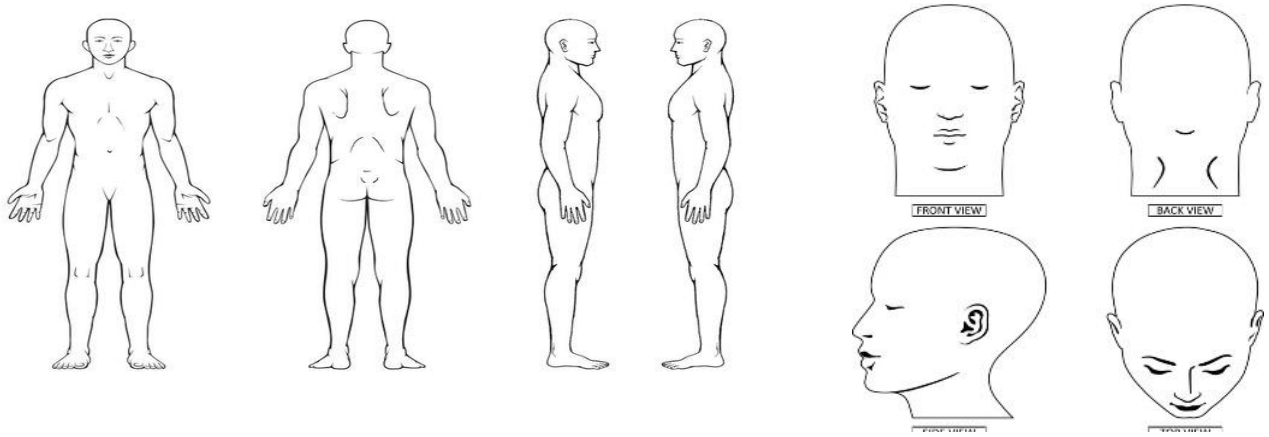
Please provide the information below to the best of your knowledge. This is needed for a more comprehensive understanding of your history and current condition. You may also need to provide more information during your discussion with your provider, and/or obtain records pertaining to previous care received.

Pain History

Are you a ☐ New Patient ☐ Returning Patient

1. Chief Complaint (Reason for your visit today)? _____
2. Please list any additional areas of pain: _____
3. What symptoms do you currently have? ☐ Pain ☐ Numbness ☐ Tingling ☐ Weakness in the arm / leg
   ☐ Balance problems ☐ Bladder incontinence ☐ Bowel incontinence ☐ Joint swelling / Stiffness
4. Does this pain radiate? If so, where? _____ _____

Use this diagram to indicate the area of your pain. Mark the location with an "X



5. How did the pain begin? ☐ Gradually ☐ Suddenly
6. Since the pain began, has it changed? ☐ Decreased ☐ Increased ☐ Remained the same
7. Approximately when did this pain begin? _____
8. How long have you been having these symptoms? _____
9. Was there any accident or trauma prior to noticing these symptoms? _____

Pain Description

10. **Check all of the following that describe your pain:**

☐ Aching	☐ Numb	☐ Shock	☐ Stinging
☐ Burning	☐ Pinching	☐ Shooting	☐ Tender
☐ Cramping	☐ Pins & Needles	☐ Spasm	☐ Throbbing
☐ Dull	☐ Pressure	☐ Squeezing	☐ Tingling
☐ Fire / Hot	☐ Sharp	☐ Stabbing	☐ Tight

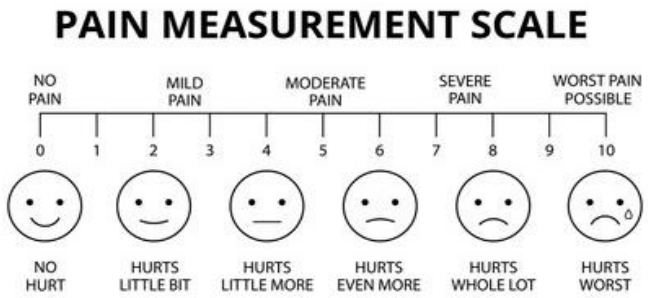
11. **When is your pain at its worst?**

☐ Mornings ☐ Daytime ☐ Evenings ☐ Middle of the Night ☐ Always the same

12. **How often does the pain occur?**

☐ Constant ☐ Intermittent (comes and goes) ☐ Changes in severity but always present

13. **If pain "0" is no pain and "10" is the worse pain you can imagine, how would you rate your pain?**



Right now: _____ The best it gets: _____ The worse it gets: _____

14. **What are the goals that you want to achieve with pain management?** _____

_____

Diagnostic Tests and Imaging

Mark all of the following tests that you have had related to your current complaints:

☐ MRI of the _____ Date: _____
☐ X-ray of the _____ Date: _____
☐ CT scan of the _____ Date: _____
☐ EMG/NCV of the _____ Date: _____
☐ Other Diagnostic Imaging: _____ Date: _____
☐ I have not had ANY diagnostic test for my current pain complaint.

Treatment History

Mark the following treatment that you have had for pain relief:

	No change	Worsened pain	Helped pain	Date
Spine surgery	☐	☐	☐	_____
Physical therapy	☐	☐	☐	_____
Chiropractic care	☐	☐	☐	_____
Psychological therapy	☐	☐	☐	_____
Brace support	☐	☐	☐	_____
Acupuncture	☐	☐	☐	_____
Hot / Cold packs	☐	☐	☐	_____
Massage therapy	☐	☐	☐	_____
Medications	☐	☐	☐	_____
Tens Unit	☐	☐	☐	_____
Other	☐	☐	☐	_____

☐ I have not had ANY treatment for my current pain complaint.

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Interventional Pain Treatment History

	Date:
☐ Epidural Steroid Injection (check all levels that apply)	
☐ Cervical ☐ Thoracic ☐ Lumbar	_____
☐ Joint Injection – Joint _____	_____
☐ Medical Branch Block / Facet Injections (check all levels that apply)	
☐ Cervical ☐ Thoracic ☐ Lumbar	_____
☐ Nerve Blocks – Area / Nerve (s) _____	_____
☐ Radiofrequency Nerve Ablation	
☐ Cervical ☐ Thoracic ☐ Lumbar	_____
☐ Spinal Cord Stimulator ☐ Trial ☐ Permanent	_____
☐ Trigger Point injections: Where? _____	_____
☐ Vertebroplasty / Kyphoplasty – Level(s) _____	_____
☐ Other: _____	_____

Which of these procedures listed above have helped with your pain? _____

_____

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist	☐ Neurosurgeon	☐ Psychiatrist / Psychologist
☐ Chiropractor	☐ Orthopedic Surgeon	☐ Rheumatologist
☐ Internist	☐ Physical Therapist	☐ Neurologist

☐ Other: _____

Who is currently managing your pain/condition?

Doctor/Facility name(s): _____

When was your last visit with this doctor? _____

Have you ever been to a Pain Management Physician? _____ Yes _____ No

Doctor/Facility name(s): _____

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Current Medications

Are you taking any aspirin, blood thinners or anticoagulants? ☐ Yes ☐ No

If yes, which ones? ☐ Coumadin ☐ Plavix ☐ Lovenox ☐ Other _____

Please list the names of all medication you are taking including vitamins:

	Medication Name	Dose	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

Please list all past pain medication that you have taken at any point for your current pain complaints.

1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Please only answer if any of your medications cause constipation. If not, skip this section.

On average, how often do you have a bowel movement? Please check one:

☐ More than 3 times per day ☐ 2 to 3 times per day ☐ Once per day
☐ 2 to 3 times per week ☐ Less than once per week

Did your bowel habits change since taking pain medicine? ☐ Yes ☐ No

How? _____

Do you have any drug/medication allergies? ☐ Yes ☐ No

Allergies (medication or substances you have had adverse reactions to:

Substance/drug	Reaction:
_____	_____
_____	_____
_____	_____

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Medical History

Please check all that apply.

Cardiac/Vascular :
- ☐ Hypertension/High blood pressure
- ☐ Heart disease/failure
- ☐ Heart rhythm problem
- ☐ Valve disease

Respiratory:
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Sleep Apnea

Endocrine:
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Adrenal disease

Musculoskeletal:
- ☐ Back pain
- ☐ Bone pain
- ☐ Height Loss
- ☐ Joint Deformity
- ☐ Joint Effusion
- ☐ Joint Pain
- ☐ Knee problems
- ☐ Joint Stiffness
- ☐ Muscle Cramps
- ☐ Muscle Spasms
- ☐ Muscle Weakness
- ☐ Myalgia

Hematologic:
- ☐ Anemia
- ☐ Leukemia
- ☐ Sickle Cell Disease
- ☐ Other bleeding disorders
- ☐ Blood Clots
- ☐ Hemophilia
- ☐ Other bleeding disorders
- ☐ Blood Clots

Other Conditions:
- ☐ Cancer : Type_____
- ☐ Cataract
- ☐ Glaucoma

Exposures:
- ☐ Syphilis/Gonorrhea
- ☐ HIV/AIDS
- ☐ Herpes
- ☐ Rabies
- ☐ Chemotherapy/radiation
- ☐ Heavy metals/Pesticides
- ☐ Hepatitis B
- ☐ Hepatitis C

Gastrointestinal:
- ☐ Acid Reflux
- ☐ Ulcers
- ☐ Hepatitis ____
- ☐ Cirrhosis
- ☐ Irritable Bowel Syndrome (IBS)

Constitutional:
- ☐ Activity change
- ☐ Appetite change
- ☐ Chills/Rigors
- ☐ Fatigue
- ☐ Fever
- ☐ Increased Fatigue
- ☐ Insomnia
- ☐ Irritability
- ☐ Malaise
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

Neurologic/Muscular/Skeletal:
- ☐ Stroke/Transient ischemic attack (TIA)
- ☐ Seizure Disorders
- ☐ Polio
- ☐ Amyotrophic lateral sclerosis (ALS)
- ☐ Multiple Sclerosis (MS)
- ☐ Neuropathy
- ☐ Scoliosis

Currently Pregnant/Breastfeeding:
- ☐ Yes
- ☐ No
- ☐ Not Applicable

Psychiatric:
- ☐ Altered Mental Status
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Hallucinations
- ☐ Increased Stress
- ☐ Irritability
- ☐ Mood Swings
- ☐ Nervousness
- ☐ Obsessiveness
- ☐ Paranoia
- ☐ Self-Consciousness
- ☐ Sleep Disturbance
- ☐ Suicidal Ideation
- ☐ Schizophrenia
- ☐ PTSD

Neurological:
- ☐ Balance disturbance
- ☐ Confusion
- ☐ Dizziness
- ☐ Facial Droop
- ☐ Fainting
- ☐ Gait Disturbance
- ☐ Headache
- ☐ Incontinence
- ☐ Lightheadedness
- ☐ Loss of Sensation
- ☐ Memory Loss
- ☐ Paralysis
- ☐ Muscular Weakness
- ☐ Numbness in Extremities
- ☐ Seizures
- ☐ Seizure Like Activity
- ☐ Slurred Speech
- ☐ Speech Changes
- ☐ Tremors
- ☐ Vertigo

Renal:
- ☐ Kidney Insufficiency
- ☐ Kidney Stones
- ☐ Chronic Kidney Failure
- ☐ Dialysis

SURGICAL HISTORY (please indicate date that surgery was done):

Orthopedic:
- ☐ Lumbar fusion
- ☐ Lumbar laminectomy/discectomy
- ☐ Cervical laminectomy/discectomy
- ☐ Cervical fusion
- ☐ Joint replacement (e.g. hip/knee etc.)
- ☐ Repair of fractures

Abdominal:
- ☐ Gastric bypass
- ☐ Appendectomy
- ☐ Cholecystectomy (gall bladder)
- ☐ Intestinal surgery/repair

Head and neck:
- ☐ Eye surgery
- ☐ Nose/sinus surgery
- ☐ Ear surgery
- ☐ Tonsillectomy
- ☐ Thyroidectomy

Urologic:
- ☐ Bladder suspension
- ☐ Kidney surgery
- ☐ Prostatectomy
- ☐ Vasectomy

Chest/heart:
- ☐ Coronary bypass graft
- ☐ Stent placement
- ☐ Valve replacement
- ☐ Pacemaker
- ☐ Lung surgery

Obstectric/Gynecologic:
- ☐ Tubal ligation
- ☐ D&C
- ☐ Hysterectomy
- ☐ C-Section

Other surgeries: _____

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FAMILY AND SOCIAL HISTORY

Tobacco use: ☐ Never ☐ Current **How many?** ___ Per day/week
☐ Former Year quit: ____ Age started ____ Age stopped _____

Alcohol: ☐ Never ☐ Current **Frequency**: ☐ Daily ☐ Frequent ☐ Occasional ☐Rarely ☐ Socially

OPIOID RISK TOOL (Mark each box that applies)

	Female	Male
1. Family History of Substance Abuse		
Alcohol		
Spouse (husband or wife)	☐ [1]	☐ [3]
Children (son or daughter)	☐ [1]	☐ [3]
Parent/Grandparent	☐ [1]	☐ [3]
Aunt, Uncle, Cousin	☐ [1]	☐ [3]
Illegal Drugs		
Spouse (husband or wife)	☐ [1]	☐ [3]
Children (son or daughter)	☐ [1]	☐ [3]
Parent/Grandparent	☐ [1]	☐ [3]
Aunt, Uncle, Cousin	☐ [1]	☐ [3]
Prescription Drugs		
Spouse (husband or wife)	☐ [1]	☐ [3]
Children (son or daughter)	☐ [1]	☐ [3]
Parent/Grandparent	☐ [1]	☐ [3]
Aunt, Uncle, Cousin	☐ [1]	☐ [3]
2. Personal History of Substance Abuse (Patient)		
Alcohol	☐ [3]	☐ [3]
Illegal Drugs	☐ [4]	☐ [4]
Prescription Drugs	☐ [5]	☐ [5]
3. Age (mark box if between 16-45)	☐ [1]	☐ [1]
4. History of Preadolescent (9-12 years old) Sexual Abuse	☐ [3]	☐ [0]
5. Psychological Disease		
Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	☐ [2]	☐ [2]
Depression	☐ [1]	☐ [1]
For office coding:	_____	_____

Low score = 0 to 3
Moderate score = 4 to 7
High score = ≥8

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PATIENT HEALTH QUESTIONNAIRE

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use ✓ to indicate your answer)

	Not at all	Several Days	More than half the days	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 thoughts of hurting yourself.	[0]	[1]	[2]	[3]
For office coding: Add columns		**+**	**+**	
For office coding: Total Score				

10. If you have 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 _____

Total score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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SOAPP –R Questionnaire

The following are questions given to patients who are on or are being considered for medication for their pain. Please answer each question as honestly as possible.
There are no right or wrong answers. **(Use ✓ to indicate your answer)**

	0 Never	1 Seldom	2 Sometimes	3 Often	4 Very often
1. How often do you have mood swings?					
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things were just too overwhelming that you just can't handle them?					
5. How often is there tension in the home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with drugs or alcohol?					
14. How often have others told you that you have a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or have been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medications from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					

Sum of questions	SOAPP-R Indication
≥ or = 18	+
<18	-

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Last name: _____First Name:_____ DOB:___/___/___ Today's date: __/___/___

2022 Opioid Contract –Informed Consent- Office Care Guidelines

The following is an agreement between the patient and Metro Spine concerning the use of controlled substance medication, informed consent for the prescribing of controlled substances, as well as office guidelines for continued care. By signing this form, you are agreeing to follow the guidelines set forth by this practice. Failure to comply may result in termination of the patient-provider relationship through Metro Spine and possible notification to Federal, State, or Local Law Enforcement authorities if a crime is believed to have been committed with your failure to comply with this agreement.

PLEASE INITIAL ALL AREAS. Your initials certify that you agree to all policies of the office. Non-compliance may result in the discontinuation of care at our facility.

_____1. I understand that controlled substance medication prescribed by Metro Spine is for my use only. I will not share my medication with any other person.

_____2. I understand that selling or sharing my prescribed medications is illegal and is a Felony Crime.

_____3. I understand that I cannot use an illegal drug, drink alcoholic beverages, or use another's prescribed medications while I am a patient at Metro Spine.

_____4. I understand that if I lose or misplace my medication, it may not be replaced.

_____5. I will safeguard my medication from theft by using a lockbox at my home, this protects myself and others around me. **Stolen medication may not be replaced**.

_____6. I understand that my controlled substance prescriptions can only be filled at ONE pharmacy.

Name of Pharmacy_____

Location/Phone Number_____

_____7. I understand that I CANNOT obtain a controlled substance medication from any other physician/hospital/urgent care/ or medical provider outside of Metro Spine without their permission. I understand that in the event of an emergency after hours, I will seek care at the nearest emergency treatment facility or contact my general physician. Metro Spine should be contacted as soon as reasonably possible after seeking emergency medical care. No controlled substance medication prescription may be filled without the express permission of this practice. Controlled medications professionally administered inside a hospital setting are exempt from this requirement, but do need to be reported to Metro Spine at your earliest convenience.

_____8. I understand that my controlled substance prescriptions can ONLY be refilled during a scheduled office/telehealth appointment.

_____9. I understand that Metro Spine ONLY fills 30-day prescriptions. I will not be allowed to fill a controlled substance prescription any earlier than 30 days from the last fill date. **Medications may not be filled early**.

_____10. I will take my medications as prescribed by the provider who prescribed the medication. No medication adjustments can be made without consulting with and obtaining permission from Metro Spine first. It is acceptable for me to take less medication if my pain level is lower, but I should never take more than the prescribed amount to minimize accidental overdose risks.

_____11. I will only take controlled substance medications that are currently prescribed by this practice. I understand that under no circumstance may I take an old, expired, or additional controlled substance prescription.

_____12. I will not dispose of my controlled substance medication myself. Disposal of medication can only be done by a medical representative at our facility, or at a facility approved by this practice.

Last name: _____First Name:_____ DOB:___/___/___ Today's date: __/___/___

_____13. **I understand that if I am going out of town, I must schedule my travel times around my medication refill dates**. ****Metro Spine cannot allow early refills!**

_____14. I understand and agree that I am subject to random urine drug screen tests and/or pills counts at my physician's request and that I **MUST** comply in order to obtain my monthly prescription and/or continue care at Metro Spine.

_____15. I understand that my treatment at Metro Spine is private and I will not share my plan of care or medication information with other patients. This is for the safety of me and my family.

_____16. I understand that it is my responsibility to make my medication appointment for my next medication refill before I leave the office. Metro Spine will not call me to make this appointment.

_____17. I understand that if I miss my medication refill appointment, that the office will only be able to offer their first available appointment. I understand I may be without medication for a short period of time.

_____18. I will immediately report to the staff of Metro Spine if I am arrested or charged with any crime related to the abuse and/or selling of any prescribed or illegal drug. Failure to report your arrest may result in termination from the practice.

_____19. I agree to keep my billing account with Metro Spine in "Good Standings" at all time. I understand that failing to make timely payments on my account may result in a referral to a collection agency, weaning of my medications, and possible discharge from the practice.

_____20. I understand that honesty is part of the foundation of a good doctor-patient relationship in order to receive the best care possible at Metro Spine. I agree to be completely honest with Metro Spine staff. I understand that failure to be honest with Metro Spine staff will be considered a breakdown in the doctor-patient relationship and may result in my discontinuation of care.

_____21. I understand that for the safety of myself and others around me and in accordance with State Medical Board Rules; this practice may issue me a prescription for a Naloxone product. I agree it is my duty to fill the prescription and keep it readily at hand in case of an accidental medication overdose.

_____22. I agree to be professional and courteous to the staff and providers at Metro Spine at all times. Threats, yelling, cursing, and/or physical violence will not be tolerated and may result in my immediate termination from the practice and possible reporting to law enforcement.

_____23. I understand and agree that the providers of this practice have the ultimate medical decision concerning my treatment plan. Medical decisions will be made on best practices for the treatment of pain and with my personal health in mind. I agree to follow the treatment plan administered by my provider and understand that not following the treatment plan may result in my termination from the practice. This treatment plan may include controlled and non-controlled medications, physical or aquatic therapy, alternative treatments, Durable Medical Equipment, psychological counseling, interventional procedures, surgical intervention, etc…

_____24. I understand that my office appointments may be conducted via telemedicine and I do hereby give my consent for the rendering of medical care via audio/video now and in the future.

PLEASE INITIAL ACCORDING TO GENDER:

_____**Females**: If I am within child bearing age, I certify that I am not pregnant and will take appropriate measures to prevent pregnancy during the course of treatment. If I become pregnant, I will notify my provider at Metro Spine immediately.

_____**Males**: I am aware that chronic opiate use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may do a blood test to check my testosterone level during my care at Metro Spine.

METRO SPINE
NON-SURGICAL PAIN INTERVENTION

OXON HILL
6196 Oxon Hill Road, Ste 510
Oxon Hill, MD 20745

CLINTON
9001 Woodyard Road, Ste A
Clinton, MD 20735

UMC
1310 Southern Ave, Ste 202
Washington, DC 20032

OFFICE: 301-856-5860
FAX: 301-856-5864

Last name: _____First Name:_____ DOB:___/___/___ Today's date: __/___/___

Additional Compliance and Billing Topics: PLEASE READ AND INITIAL

_____1. **(Compliance) I understand that my controlled substance medications may be discontinued if…**

- If I test positive for an illegal substance on a urine drug screen test
- If I test negative for any prescribed medications on a urine drug test
- If I test positive for a medication that is not currently prescribed to me
- If I do not show up or have the correct medication count at mandatory pill count appointments
- If I NO SHOW or continually cancel office visit appointments or scheduled interventional procedures
- If my billing account becomes delinquent
- If I do not comply with treatment suggested by my provider
- If I do not cooperate in a civil manner with the staff or providers

_____2**. (BILLING) I understand that I have to have active medical insurance to be seen and obtain medications unless approved by METRO SPINE.**

- I must present my current insurance card if requested by the check in clerk.
- A government issued picture identification needs to be brought to all visits and procedures and may be asked for at random.
- Metro Spine has the right to verify active insurance through the insurance company before your visit and require a cash deposit if unable to verify current coverage.
- If I have a co-pay, it MUST be paid before you are seen.
- I understand that Metro Spine is not a creditor and although in hardship situations a payment plan may be extended to you, payments are generally due at the time of service.
- As allowed by law, No-Show fees may be charged for same day appointment and procedure cancellations. These fees must be paid in cash or credit and will not be billed to your medical insurance provider.

_____3**. (Risks of Medication Use) I understand physical dependence is a normal expected outcome of using long term controlled substance medications.**

- I am aware that the tolerance to analgesia means that I may require more medicine or need to rotate medications to get the same amount of relief.
- I understand that Metro Spine's goal is to minimize controlled substance usage while controlling my conditions with interventional or therapeutic methods.
- I understand that opiate medications offer no disease modifying components and only treat the symptoms of your condition in the short term. Interventional treatment or devices may be recommended by Metro Spine for a more long-term direct relief approach to your condition.
- Metro Spine reserves the right to intervene with controlled medication treatments by using therapeutic and/or interventional treatment methods to help lower the narcotic dose and relieve pain.
- I understand that there is a risk that opiate addiction may occur. This means that I may become psychologically dependent on the medication. If this occurs, the medication will be stopped and I will be referred to appropriate substance abuse treatment.
- I agree to minimize, safely wean, or discontinue use of Benzodiazepines if prescribed Opiates by Metro Spine due to extreme risk of accidental overdose and black box warning by the FDA. **Benzodiazepines may not be prescribed by Metro Spine on a long-term basis.**
- I understand that the risks and side effects of opiate medications are:
  -Sedation, drowsiness, feeling sleepy
  -Confusion, change of ability to think clear
  -Difficulty with balance –**DO NOT operate heavy equipment or drive motor vehicles**
  -Constipation, nausea, vomiting
  -Decrease in respiration or breathing- Extreme risk of accidental overdose when taken with a benzodiazepine- such as Ativan, Lorazepam, Xanax, Valium, Diazepam.

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Last name: _____First Name:_____ DOB:___/___/___ Today's date: __/___/___

By signing this agreement; I hereby agree that:

I have read, agreed to, and understand the aforementioned agreement.

I am fully aware that this contract and office policies are in place to assist with my safety, compliance, and well-being.

I am willing to comply with the individualized plan of care recommended by all providers at Metro Spine.

I will fully comply with all aspects of this agreement until my care at Metro Spine is discontinued.

I understand that this contract will be renewed yearly in order to continue care with Metro Spine.

I hereby authorize my Pharmacy of Record to release any and all patient information to Metro Spine staff for the purpose of medication compliance and my continued patient care.

I hereby authorize any past, present, or future medical treatment providers to release my personal medical information and patient medical records, at the request of Metro Spine. I further authorize the medical treatment provider to discuss my medical treatment and/or medical care with Metro Spine upon their request.

I agree that I have had ample opportunity to ask any questions regarding this agreement or my patient care with my Metro Spine provider to my satisfaction.

Printed Patient Name:_____ Date: _____

Patients Signature: _____

Metro Spine's Staff Witness: _____

Metro Spine's Provider Signature:_____

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Last name: _____First Name:_____ DOB:___/___/___ Today's date: __/___/___

I hereby acknowledge that I have received a copy of:

1. Office Policies
2. Information concerning prescription refills.

Signature:	**Date:**

Notice of Privacy Practices:

I hereby acknowledge that I have received a copy of Metro Spine Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

Signature:	**Date:**

Printed Name of Patient's Representative (if applicable), Relationship to Patient (if applicable), Parent or guardian of Unemancipated Minor, Court Appointed Guardian, Executor or Administrator of Decedent's Estate Power of Attorney.

Disclosure of Medical Information:

I hereby authorize the use of disclosure of my individual identifiable protected health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a Health Plan, a Federal Organization or Healthcare Provider, the release of information may no longer be protected by Federal privacy regulations.

This authorization is valid from today's date _____ until _____

This authorization is for all my healthcare information except the following:

_____

Persons or entities that information can be disclosed:

_____

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Notice of Privacy Practices for CRISP Participation

CRISP: Connecting Physicians with Technology to Improve Patient Care in Maryland

Metro Spine PC has chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a regional health information exchange. As permitted by law, your health informatino will be shared with this exchange in order to provide faster access, better coordination of acare and assist providers and public health officials in makingmore informed decisions. You may "opt-out and disble all access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org.

Public health reporting and Controlled Dangerous Substances Information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

I have read the above statement and I am aware that my personal healthcare will be accessed.

Signature:	**Date:**

Opt-Out (Patient must call CRISP or complete opt-out and send in the mail).

Signature:	**Date:**

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FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date:

_____

But acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time. We will attempt again at a later date.
- ☐ Communication barriers prohibited the obtaining of acknowledgment (please explain below):

_____

_____

_____