Michigan Interventional
Pain Associates

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Board Certified, American Board of Anesthesiology
Subspecialty Certification in Pain Medicine

-Important-

Please completely fill-out our new patient package and return to our office by mail in the enclosed return envelope as soon as possible. Allow 2 days for mailing to ensure we receive it in a timely manner.

Options to complete the new patient package:

1. **Website Link:** www.MiPainClinic.com
   -Click on "New Patients" tab at top of webpage
   -Scroll down No. 4 "New Patient Information Online Form"
   -Answer all the questions/fields-*Be sure to have time to answer, information will not be saved if idle too long.*
   -Click "Submit" button, once clicked, the information will be sent directly to the office
2. **Scan/Email** (download & print from website)
   -email to: Mipa@lakespm.com
3. **Fax** (download & print from website)
   -number is: 248-624-2597
4. **Mail/Drop off**
   - Michigan Interventional Pain Associates
     2300 Haggerty Rd. Suite 2100
     West Bloomfield, MI 48323

Office Hours:
Mon-Thur: 8:00am-4:45pm
Friday: Closed

We need to receive the new patient package completely filled-out, 2 days prior to your appointment. If we do not receive it, you will need to arrive 1 hour earlier than your scheduled appointment time to complete it in office.

If you have any questions, please feel free to contact the office at (248)-624-7246.
Thank you

MICHIGAN INTERVENTIONAL PAIN ASSOCIATES

DATE:		
PATIENT NAME:		
ADDRESS:		
CITY:	STATE:	ZIP:
DATE OF BIRTH:	SSN:	
MARITAL STATUS: ___ SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED ___ SEPARATED		
EMPLOYER:	OCCUPATION:	
REFERRING DOCTOR:	ADDRESS/PHONE #:	
ADVANCE DIRECTIVES: ___ GUARDIANSHIP ___ LIVING WILL ___ POWER OF ATTORNEY ___ NOT ESTABLISHED		

CONTACT INFORMATION

HOME PHONE #:	PHARMACY NAME: CROSS STREETS/CITY: PHONE #:	
WORK PHONE #:	EMAIL:	
CELL PHONE #:	WHERE DO YOU PREFER TO RECEIVE YOUR CALLS?: ___HOME ___WORK ___CELL	
CAN WE LEAVE A MESSAGE?: ___ YES ___NO		
EMERGENCY CONTACT?: Name_____ Relationship to patient_____	Cell #	Work#

INSURANCE INFORMATION

PRIMARY INSURANCE:	SECONDARY INURANCE:
NAME OF SUBSCRIBER:	NAME OF SUBSCRIBER:
RELATIONSHIP TO PATIENT:	RELATIONSHIP TO PATIENT:
SUBSCRIBER'S DATE OF BIRTH:	SUBSCRIBER'S DATE OF BIRTH:
CONTRACT/ENROLLEE ID #:	CONTRACT/ENROLLEE ID #:
GROUP #:	GROUP #:
CUSTOMER SERVICE #:	CUSTOMER SERVICE #:

Auto/ Workman's Compensation?: ___ Auto ___Workman's Compensation

(Need to obtain Open Claims Billable Letter BEFORE Apt):

1. Insurance Company: _____
2. Claim Adjuster Name: _____
3. Claim Adjuster #: _____
4. Claim No.: _____
5. Date of Injury/Loss: _____

I hereby certify that the above information is correct and true.

Patient Signature _____

Patient Representative _____

Relationship to Patient _____ Date _____

MICHIGAN INTERVENTIONAL PAIN ASSOCIATES

Please fill out the following questionnaire and bring it with you to your appointment. In addition, bring your medication list and REPORTS of any X-rays, MRI or Cat scans.

Patient's name: _____

Age: _____ Birthdate: _____

Appointment date: _____ Arrival time: _____

Referring Physician _____

Address/Phone Number _____

_____

_____

Primary Physician _____

Address/Phone Number _____

_____

_____

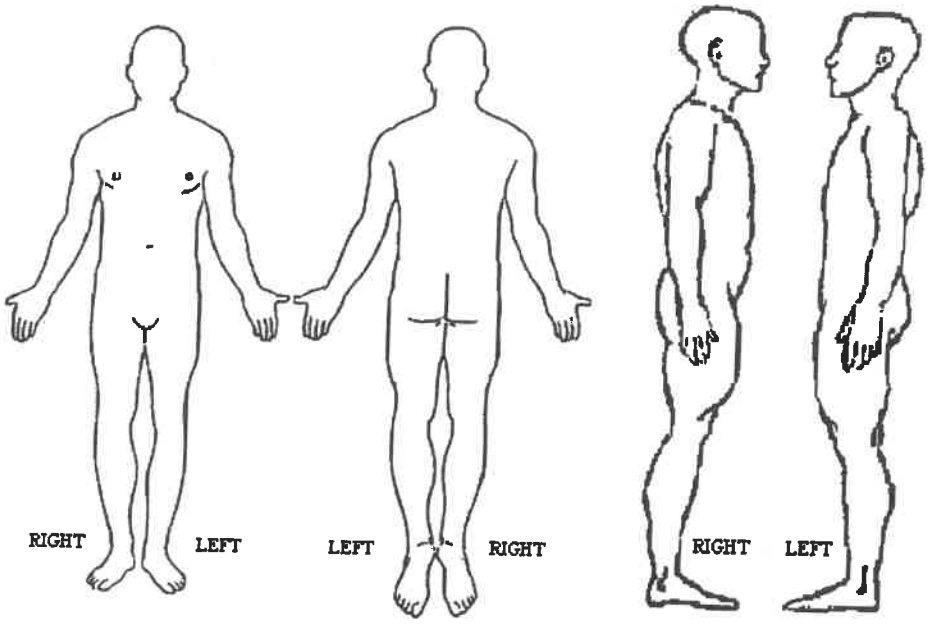
IF YOUR INSURANCE REQUIRES A PRE – AUTHORIZATION / REFERRAL FORM, PLEASE OBTAIN PRIOR TO YOUR VISIT.

In order to facilitate your care, it is essential you complete all attached forms. While we understand this may be difficult, it is important we learn as much about you as we can.

Some questions may seem unrelated to your problem, but pain is a very complex issue, so please complete this document to the best of your ability.

Upon your arrival, a member of MIPA will review this questionnaire with you. You will then be evaluated by a physician.

PLEASE SHADE IN THE AREA WHERE YOUR PAIN OCCURS



HISTORY OF PRESENT ILLNESS

Under what circumstances did your pain begin? (Check all that applies)

[ ]accident at work [ ]accident at home [ ]work related [ ]pain just began
[ ]motor vehicle accident [ ]following surgery [ ]following illness

If your pain began with a work related accident, please provide the following:
Place of employment_____
Date of injury _____
Type of work_____

What were you doing when the pain occurred

_____
_____
_____
_____
_____

On the scale below, place a mark on the graph to represent the severity of your pain. "0" is no pain and "10" is the worse pain imaginable

Currently, what is your pain score?

!-------!-------!-------!-------!-------!-------!-------!-------!-------!-------!-------!

0 1 2 3 4 5 6 7 8 9 10

What is the highest your pain score that you have ever had?

!-------!-------!-------!-------!-------!-------!-------!-------!-------!-------!-------!

0 1 2 3 4 5 6 7 8 9 10

What is the lowest pain score that you have ever had?

!-------!-------!-------!-------!-------!-------!-------!-------!-------!-------!-------!

0 1 2 3 4 5 6 7 8 9 10

Duration: How long have you had this pain problem? _____ yrs /months/days
When did you first notice your pain?_____

Timing of your pain (when is it the worst):
[ ]First thing in the morning [ ]Later in the morning [ ]Afternoon
[ ]Evening [ ]Bedtime [ ]Pain is ALWAYS the same

Quality of your pain (how would you best describe your pain:
[ ]Burning [ ]Sharp [ ]Aching [ ]Throbbing [ ]Shooting [ ]Other

Associated signs and symptoms:
[ ]Numbness [ ]Tingling [ ]Pins and Needles [ ]Weakness [ ]Coldness
[ ]Swelling [ ]Muscle Spasm [ ]Tightness [ ]Skin Discoloration
[ ]Bowel or Bladder Problems.

What activities increase your pain:
[ ]Sitting [ ]Standing [ ]Lying [ ]Worry/Stress [ ]Driving
[ ]Walking [ ]Weather [ ]Time of Day [ ]Activities [ ]Sex

Which of the following decrease your pain:
[ ]Rest [ ]Lying [ ]Sitting [ ]Standing [ ]Drug/Alcohol
[ ]Physical Activity [ ]Time of Day

Please indicate which of the following you have tried if any.

	Was it helpful?	How long was it helpful	Date of last treatment / use
Acupuncture	Yes / No		
Biofeedback	Yes / No		
Chiropractor	Yes / No		
Heat	Yes / No		
Hypnosis	Yes / No		
Ice	Yes / No		
Illicit (street drugs)	Yes / No		
Massage	Yes / No		
Prescribed pain medicine	Yes / No		
Physical therapy Where did you go?	Yes / No		
Nerve blocks	Yes / No		
Therapy/counseling	Yes / No		
Surgery	Yes / No		
Steroid treatment	Yes / No		
TENS	Yes / No		

Please indicate which of the following you have tried if any.

Procedure/injection	Relief	How long
	Yes / No	
	Yes / No	
	Yes / No	
	Yes / No	

Do you currently use or have you ever used-

Walker	Yes / No	
Cane	Yes / No	
Wheelchair	Yes / No	

MEDICAL HISTORY

Have you had	Y	N	Comments	Have you had	Y	N	Comments
asthma/emphysema				angina			
hypertension				diabetes			
heart attacks				arthritis			
congestive heart failure				depression			
MVP or valvular disease				sleep apnea			

REVIEW OF SYSTEMS

Have you had	Y	N	Comments	Have you had	Y	N	Comments
weight gain or loss				constipation			
fevers/chills				bone/muscle pain			
issues with eyes/vision				snoring			
issues with nose/throat				chest pain			
problems breathing				thyroid trouble			
bowel Incontinence				bleeding/bruising			
bladder incontinence				stomach pain			

Females only

First day of your last menstrual period
Are you periods normal? Yes / No
Any abnormal vaginal / breast discharge? Yes / No
Number of pregnancies_____ Number of deliveries_____

PAST SURGICAL HISTORY

Please list all the operations you have undergone, including the year they were performed.

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

MEDICATIONS

Please list all the medications you are currently taking, including the dosage.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

What pain medications have you tried in the past for your pain?

DRUG ALLERGIES/SENSITIVITY – REACTION

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

Environmental / Food Allergies: (mold, dust, pollen, cats, dogs, eggs…)

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

PERSONAL HABITS:

Do you smoke? _____ how much per day _____
If no, are you a previous smoker? _____
Do you drink alcohol? _____ If yes, how much? _____
Have you ever had a problem with drugs or alcohol? _____
Do you have a history of illicit drug use? _____
How many caffeinated beverages do you consume daily _____
How often do you see a doctor?
[ ]3 or more times per month [ ]1 – 2 times per month [ ]less than once a month

SOCIAL/OCCUPATIONAL HISTORY

Marital Status: Single Married Widowed Divorced Separated Remarried

Spouse's name _____

Number of children? _____ Ages? _____

Who shares your home? _____

Occupation _____ How long at this position? _____

Brief description of job duties _____

Work Status: Full Time Part Time Student Disabled Unemployed Retired

If disabled, date last worked _____

If working less than full time is pain the reason?
_____
If you had no pain would you return to work?
_____
Has your employer been helpful and understanding of your problem?
yes or no? _____

What would you hope to be the end result of this evaluation? (Please circle)
Medical diagnosis / Recommendations for surgery / Recommendations for medications
Recommendations for rehabilitation

If you are treated here, what are the results you HOPE for? (Please circle)
Pain reduction / Increased recreation / Improved emotional well- being
Increased socialization / Return to work

If you are treated here, what are the results you EXPECT?
1. _____
2. _____
3. _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement HIPAA/@Notice of Privacy Practices.doc officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to

you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

Lakes Medical Center

Michigan Interventional Pain Associates
2300 Haggerty Rd Ste 2100
West Bloomfield, MI 48323
P-248-624-7246
Located in the Lakes Medical Center on the SE corner of Haggerty Rd & Pontiac Trail