Consent for General Treatment for Ambulatory and Virtual Care:
I understand and agree that as a patient I will receive general medical services and treatment. I understand I have the right to ask questions about and refuse these services. Providers may include advanced practitioners in your care.
I acknowledge that I have the right to refuse care or withdraw my consent for care, without affecting my right to future care or treatment. I understand that it is my duty to inform my providers and clinicians regarding the care that I may have received with other healthcare providers. I authorize all clinical providers who provide care to me, along with any billing services or other agents who may work on their behalf to contact me on my cell phone and/or home phone using automated telephone dialing systems, email messages, text messages or other computer assisted technology. I further authorize them to leave a detailed voice message on my cell phone and/or home phone.

Financial Responsibility Agreement:
I understand that in consideration of the services provided I agree to pay charges according to Nerve and Pain Institute regular rates and terms. I understand and agree that Nerve and Pain Institute may make inquiries regarding insurance coverage and my financial responsibility from third party payors or other responsible parties. In addition, I give consent for these payors and/or references to release information to Nerve and Pain Institute. I understand that Nerve and Pain Institute reserves the right to require proof of my ability to pay and may require a payment prior to service. I further understand that payments collected will be applied to my total bill owed. I authorize direct payment to Nerve and Pain Institute and/or health care providers during this period of medical care any third party, insurance, or liability benefits otherwise payable to me. I also authorize direct payment to the surgeon and/or physician or anesthesiologist any third party/insurance benefits which may be due under this claim. If I am applying for payment under Medicare, Medicaid, or TRICARE, I certify that the information I give is correct. I request benefit payments be made directly to Nerve and Pain Institute. I further agree to pay for services denied or not covered by my insurance regardless of the reason for denial or non-coverage.

Cancellation, late arrival and missed appointment:
If you cancel your appointment with less than 24 hour notice or missed your appointment, we reserve the right to charge you a **$50 cancellation fee**.

Authorization to Disclose Health Information:
I authorize the use or disclosure my health information from/to my referring physician and other specialists involved in my care. The type and amount of information to be used or disclosed is the entire medical chart including medical records, office notes, hospital records, pharmaceutical records, laboratory records, X-ray and MRI films, CT scans, any other radiological films, and medical bills. I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, pregnancy, and/or family planning.

Virtual Care: Nerve and Pain Institute utilizes video conferencing software to conduct virtual care visits. Nerve and Pain Institute may also utilize telephone and secure electronic messaging to conduct virtual care visits. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption and use.

Email/Text Messages: E-mails from health care providers will be encrypted. However, email and text messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients. Nerve and Pain Institute cannot guarantee the security and confidentiality (privacy) of e-mail/text messaging communication, and will not be liable for improper use and/or disclosure of confidential information. I understand the risks associated with the communication of e-mail or text messages. I consent to e-mail and text messages for confidential information among health care provider and/or practice, other healthcare providers participating in my care, and me.

Non-Discrimination Policy: Nerve and Pain Institute provides services to all people. It does not discriminate against any patient because of race, religion, national origin, gender, sexual orientation, disability.

Personal Property and Valuables – Patient Waiver of Liability: Nerve and Pain Institute is not responsible for loss or damage to personal property or medications brought to the hospital. Patients are advised to leave valuable items at home or to send valuables home with a responsible person.

I am the patient or the patient's agent or authorized representative. I acknowledge that I have read this agreement and understand its purpose and contents. By signing here, I consent for health care services and accept the terms of the financial agreement.

_____	_____	_____
Print Patient Name	Signature	Date

PATIENT MEDICAL HISTORY

Last Name _____ First _____ MI _____

Date of Birth _____Age_____ Height _____ Weight _____ □ Male □ Female

Address _____

Home Phone _____

E-mail Address_____

Occupation _____

CURRENT MEDICATIONS

List all medications that you are taking (prescriptions and over-the-counter).

Medication	Daily Dose	How Often	
1_____	_____	_____	_____
2_____	_____	_____	_____
3_____	_____	_____	_____
4_____	_____	_____	_____
5_____	_____	_____	_____
6_____	_____	_____	_____
7_____	_____	_____	_____
8_____	_____	_____	_____

PAST MEDICAL HISTORY (Medical problems, such as hypertension, diabetes, atrial fibrillation)

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

ALLERGIES

Medication or injection	Reaction	Year
1_____	_____	_____
2_____	_____	_____
3_____	_____	_____
4_____	_____	_____

SOCIAL HISTORY

Do you smoke? □ No □ Yes How Long: _____ How Much: _____

What do you smoke? □ Cigarettes □ Cigars □ Pipe

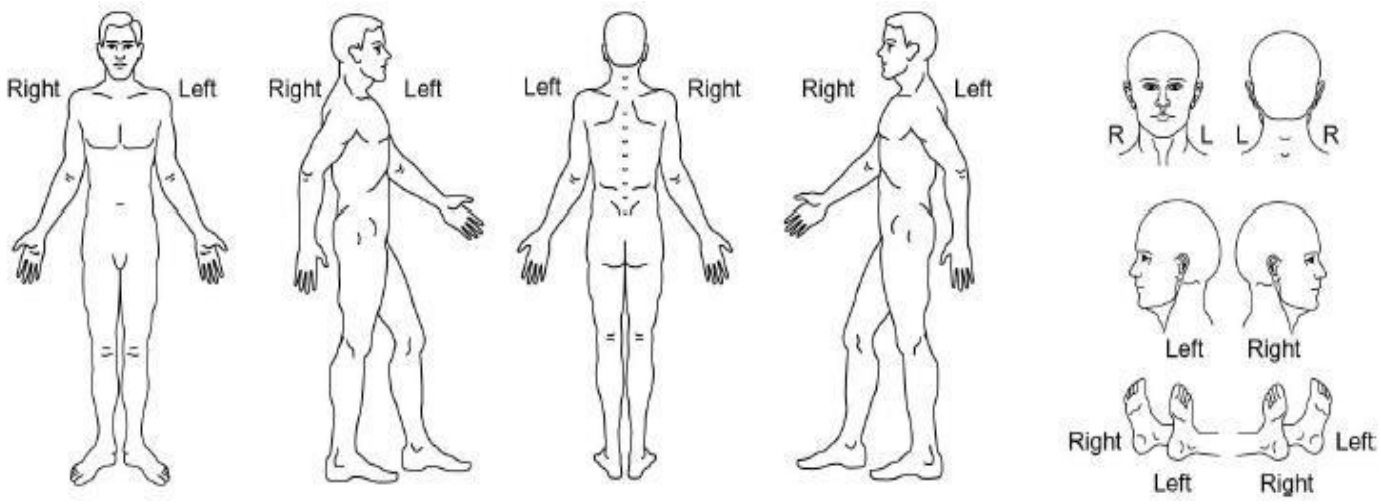
Have you stopped? □ No □ Yes When: _____

Do you drink alcohol? □ No □ Yes

How Much? □ 1 drink/day □ 2 oz./day □ 4 oz./day □ More

PAIN HISTORY (only fill out if you have pain)

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



Approximately, when did this pain begin?_____

What are the goals you wish to achieve with Pain Management? _____

Physical therapy

List the physical therapy you have completed

Month/year

1_____

2_____

3_____

4_____

5_____

Diagnostic Testing:

□ MRI cervical spine. Date:_____ Location:_____
□ MRI lumbar spine. Date:_____ Location:_____
□ EMG. Date:_____ Location:_____
□ Other imaging studies: _____

Interventional Pain Treatment history: Did it help?

□ Epidural steroid injection: Cervical/Thoracic/Lumbar (circle all applied). □ Yes □ No

□ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar □ Yes □ No

□ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar □ Yes □ No

□ Nerve Blocks – Area/Nerve(s) - _____ □ Yes □ No

□ Spinal Cord Stimulator – Trial Only/Permanent Implant _____ □ Yes □ No

□ Other treatments:_____

Pain scale	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
1. I worry all the time about whether the pain will end.	0	1	2	3	4
2. I feel I can't go on.	0	1	2	3	4
3. It's terrible and I think it's never going to get any better.	0	1	2	3	4
4. It's awful and I feel that it overwhelms me	0	1	2	3	4
5. I feel I can't stand it anymore.	0	1	2	3	4
6. I become afraid that the pain may get worse.	0	1	2	3	4
7. I think of other painful experiences.	0	1	2	3	4
8. I anxiously want the pain to go away.	0	1	2	3	4
9. I can't seem to keep it out of my mind.	0	1	2	3	4
10. I keep thinking about how much it hurts.	0	1	2	3	4
11. I keep thinking about how badly I want the pain to stop.	0	1	2	3	4
12. There is nothing I can do to reduce the intensity of the pain.	0	1	2	3	4
13. I wonder whether something serious may happen.	0	1	2	3	4
Total score					