Minimally Invasive Pain Specialists

New Patient Intake Form

Patient Information

Height:______________________**Weight**: ______________________

Referring Physician:_________________________**Primary Care Physician**: _______________________________

Pain History

Chief Complaint (Reason for your visit today)? ____

What caused your current pain episode? ____

Approximately when did this pain begin? ____

Does this pain radiate? If so where? ____

Please check the appropriate words that best describe your pain

Constant	Burning	Stabbing	Sharp	Dull/ache	Electric	Tingling	Hot/burning
Spasming	Throbbing	Tightness	Shooting	Numb	Cramping	Intermittent	Heavy

On a scale from 1 to 10, how do you rate your pain? _________

Mark the effect each of the following have on your pain level - ☑

	Increases	**Decreases**	**No Change**
Bending Backward			
Bending Forward			
Sitting			
Standing			
Walking			
Driving			
Lifting objects			
Rising from a seat			
Climbing Stairs			
Changes in Weather			
Coughing/Sneezing			
Looking up			
Looking down			

Please mark all of the following treatments you have used for pain relief: ☑

☐ Exercise/Yoga ☐ Heat/Ice

☐ Acupuncture ☐ Chiropractor

☐ Physical therapy (how many times per week and how many weeks?) ____________________

☐ Over the counter medication ____________________

☐ Prescription medication ____________________

☐ Epidural Steroid Injection – which level(s)? ____________________

☐ Joint Injection – which joint(s)? ____________________

☐ Medial Branch Blocks/Facet Injections - which levels? ____________________

☐ Radiofrequency Nerve Ablation – which levels? ____________________

☐ Trigger Point Injections – Where? ____________________

☐ Nerve Blocks – which area/nerve(s)? ____________________

☐ MILD (Minimally Invasive Lumbar Decompression) ____________________

☐ Spinal Cord Stimulator – Trial Only/Permanent Implant ____________________

☐ Vertebroplasty/Kyphoplasty – Level(s) ____________________

☐ Other - ____________________

Current Medications – Please list all prescription and over the counter, including dosages

	Medication	Dose	Frequency
1)	____________	______	______
2)	____________	______	______
3)	____________	______	______
4)	____________	______	______
5)	____________	______	______
6)	____________	______	______

Do you take Aspirin, Naprosyn/Aleve/Naproxen, Ibuprofen/Advil/Motrin, Plavix, Coumadin, Warfarin, Eliquis, Heparin, Lovenox, or any other blood thinner? (IF YES, indicate below)

____

Medical History

High Blood Pressure		Diabetes		Ulcers	
Heart Disease		Low Blood Sugar		Reflex	
Heart Murmur		Glaucoma		Colitis	
Irregular Heart Beat (pacemaker/AICD)		Blindness		Diverticulitis	
Congestive Heart Failure		Kidney Disease/Failure		Bleeding Disorder	
High Cholesterol		Bladder Problems		Hepatitis (Type)	
Deep Vein thrombosis (blood clot)		Prostate Problems		Jaundice	
Aneurysm		Pulmonary Embolism		Sickle Cell	
Stroke or TIA		Asthma		Blood Disease	
Blackout Spells		Emphysema		Anemia	
Seizures		COPD		Cancer (Type)	
Migraines		Pneumonia		Depression/Anxiety	
Parkinson's Disease		Sleep Apnea		**Other**:	
Rheumatoid Arthritis		Home Oxygen			
Weakness/Paralysis		Hiatal Hernia			

Social History

Occupation: ______________________________

When was the last time you worked? ________

Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed ☐

Are you currently under worker's compensation? ☐ No ☐ Yes

Is there an ongoing lawsuit related to your visit today? ☐ No ☐ Yes

Is there a possibility you could be pregnant?	Yes No	
Do you or have you ever smoked?	How much?	Date quit?
Do you drink alcohol? Yes No	If yes, how much?	
Do you use recreational or illegal drugs?	If yes, which drugs?	

Previous surgeries?

____

____

____

Previous Hospitalizations?

____

____

____

Allergies

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

Medication Name	Allergic Reaction
1) ______________________	______________________
2) ______________________	______________________
3) ______________________	______________________

Topical Allergies: ☐Latex ☐Iodine ☐ Tape ☐ IV Contrast

Review of Systems

General		Heart		Neurologic	
Fever		Palpitations		Headaches	
Chills		Chest tightness		Seizures	
Skin		Heart murmur		Loss of consciousness	
Rash		Swelling of feet		Paralysis	
Itching		Gastrointestinal		Muscle atrophy	
Changes in hair or nails		Change in appetite		Tremor	
Eyes/ears/nose		Problems swallowing		Involuntary movement	
Double vision		Nausea/vomiting		Numbness	
Eye pain		Heart burn		Hematologic	
Hearing loss		Constipation		Low blood count	
Ringing in ears		Diarrhea		Easy bleeding/bruising	
Room spinning (vertigo)		Abdominal pain		Past blood transfusion	
Nose bleeds		Urinary		Endocrine	
Frequent colds		Difficulty urinating		Increased thirst	
Mouth/throat		Incontinence		Heat/cold intolerance	
Bleeding gums		Musculoskeletal		Excessive sweating	
Sore throat		Swelling		Psychiatric	
Neck		Joint stiffness		Anxiety	
Lumps/goiter		Joint pain		Depression	
Lungs		Muscle pain		Suicidal thoughts	
Shortness of breath		Muscle weakness		Sleep problems	
Wheezing				Memory problems	
Cough					

Imaging Studies

X-ray Yes No Which area? _______________________________ Date ___________________
CT Yes No Which area? _______________________________ Date ___________________
MRI Yes No Which area? _______________________________ Date ___________________

Pharmacy Information

Pharmacy name: ____________________________________ Pharmacy phone: ______________________________

Pharmacy address ____

This signed authorization gives MIPS the ability to obtain, through their electronic system, all medicationinformation and prescription benefits that are available on record with the pharmacy program:

Acknowledgement of Notice of Privacy Policies

I____acknowledge that I have received the enclosed document from MIPSin regard to their Notice of Privacy Policies.

Patient Signature _______________________________ Date ____________________________

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Your signature below forms a binding agreement between, on the one hand, Minimally Invasive Pain Specialists PLLC (including Dr. Ryan Hijazi, DO) (individually and collectively, the "Practice") and, on the other hand, the undersigned Patient who is receiving medical services or the undersigned Responsible Party for patients under 18 years old or holding other legal representative status. The Responsible Party is the individual who is financially responsible for payment of medical bills.

Payment Due in Full at the Time of Service:

All charges for services rendered are due and payable in full at the time of service, regardless of whether you have insurance. You hereby waive any and all claims against Practice with respect to the processing of insurance claims and the payment of benefits from the insurance company to you.
Acceptable payment methods include cash, credit card or check.

Returned Check Policy:

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the Patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $25.00 check service charge. Once notice is received of the returned check, Practice will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $25.00 check service charge.

Missed Appointments and Late Cancellations:

You will be charged a fee of **$25.00** if you miss an appointment or fail to cancel an appointment at least 24 hours prior to your scheduled visit. You must pay this balance in full at the time of your next appointment.

Non-Payment on Account:

Should collection proceedings or other legal action become necessary to collect an overdue account and missed appointments/late cancellations, the Patient or the Patient's Responsible Party understands that Practice has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The Patient, or the Patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at a 10% per annum (or the highest rate permitted by law, if lesser), all court costs and attorneys' fees, and collection fees, which will be added to the outstanding balance. By signing below, you agree to accept full financial responsibility as a Patient who is receiving medical services, or as the Responsible Party. Your signature verifies that you have read this Patient Financial Responsibility statement, understand your responsibilities, and agree to these terms. A photocopy of this document shall be as effective and valid as the original.

Patient's Name (Print) ________________________________ Date of Birth ___________

Signature of Patient/Responsible Party ________________________ Date ______________________

If the above person is the legal representative of the patient, please write the patient name directly above, and indicate your name and legal representative status giving you the authority to sign on behalf of the patient.

PARTIES WHO MAY BE PROVIDED PROTECTED HEALTH INFORMATION (PHI)

In general, the HIPAA privacy rule gives individuals the right to request restrictions on uses and disclosures of Protected Health Information (PHI). Completion of this form tells us your preferences with regard to telephone messages and gives us information about individuals you have authorized to speak to us about your health care. Further authorization may be needed under more specific circumstances.

Patient's Name (Print) ________________________ Date of Birth ___________________________

I wish to be contacted in the following manner (fill in all that apply):

Home Tel: _____________________________ Mobile Tel: ____________________________

Email: ________________________________

A ***very important*** note about email communications:

- When we send you an email or you send us an email, the information that is sent is not encrypted.
- This means a third party may be able to access the information and read it since it is transmitted over the internet.
- In addition, once the email is received by you, someone may be able to access your email account and read it.
- Email is a very popular and convenient way to communicate for many people so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA. The information is available in a PDF (page 5634) on the U.S. Department of Health and Human Services website: http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- *The guidelines state that if a patient has been made aware of the risks of unencrypted email and that same patient provides consent to receive health information via email then a health entity may send that patient personal medical information via unencrypted email.*

******PLEASE SELECT (MARK WITH A √) ONE OF THE TWO OPTIONS BELOW******

[ ] OPTION 1: ALLOW UNENCRYPTED EMAIL
I understand the risks of unencrypted email and do hereby give permission to Minimally Invasive Pain Specialists PLLC to send me personal health information via unencrypted email.

[ ] OPTION 2: DO NOT ALLOW UNENCRYPTED EMAIL
I do not wish to receive personal health information via email.

Other individuals I authorize to take messages or receive PHI are (fill in all that apply):

Place a check mark here if you do NOT authorize any other individuals to take messages or receive PHI

Spouse Name: ________________________

Ok to provide all medical information, including complete medical records? Yes No

Other individual: ______________________________________

Relationship to you: ____________________________________

Ok to provide all medical information, including complete medical records? Yes No

Signature of patient/parent/guardian ______________________________ Date ______________________