Interventional Spine Center,
Pain Management Associates

RELEASE OF MEDICAL RECORDS

I authorize my previous treating physician to release the following medical records to Pain Management Associates, Inc.:

- Recent visit note
- Any procedure notes
- Any imaging reports (i.e. MRI, CT Scans, X-rays)
- Medication list
- Any other pertinent medical records

This authorization will expire six months after it is signed.

Purpose:

Continued Medical Care	External Quality/ Utilization Review	Claim Processing
Personal Interest	Insurance Claim Processing	Other

Refusal to Sign/Right to Revoke: I understand I may refuse to sign and have the right to revoke this authorization at any time, and revocation must be provided to Pain Management Associates, Inc. at the address listed below. The revocation must be presented to the person that was handling my medical records. I understand that treatment, payment, enrollment to any health plan or eligibility for health benefits are not affected by signing this authorization.

These records are to be faxed to 877-763-6131

Patient Name: ____ DOB: ___________________________

Patient Signature: ____ Date: ___________________________

Interventional Spine Center,
Pain Management Associates

OPIOID CONTRACT

Controlled substances, such as narcotics, tranquilizers, and barbiturates are very useful, but have high potential for misuse. They are intended to relieve pain specifically to improve function and/or ability to work, not simply to feelgood. Please carefully read and sign at the end of this form that you have agreed with the following conditions that Interventional Spine Center, Inc. & Pain Management Associates, Inc. have listed below.

I am responsible for my controlled substance medication. If the prescription is lost, misplaced, stolen, or if I have used it up sooner than prescribed, I understand that it will not be replaced.
I will not request or accept controlled substance medication from any other Physician or from any other source while I am receiving medication(s) from Interventional Spine Center, Inc. & Pain Management Associates, Inc. without permission. A prescriber-lock will be implemented to ensure this agreement.
There will be no early refills. Prescription for refills will be written at my next office visit. They will not be made if Irun out early for any reason including if I lose a prescription or spill/misplace the medication.
I understand that it is the policy of Interventional Spine Center, Inc. & Pain Management Associates, Inc. to refill my medication(s) at the time of my scheduled office visit and that there will not be any medication(s) that shall be called into the pharmacy.
I agree to comply with random urine, blood, or breathing test to document the proper uses of the medication(s). I understand that if I am told that I am impaired by certified personnel, that I will not drive a motor vehicle or operate any other heavy machinery.
I further understand that driving a motor vehicle may not be allowed at times while taking controlled substances. It is my responsibility to comply with the laws of the state while taking these medications.
I agree to waive any applicable privilege or right of privacy or confidentiality with respect of prescribing my pain medication.
I understand that the following possible side effects may occur, and are not limited to: sedation, itching, nausea, vomiting, difficulty urinating, and/or constipation.
I further understand that a possibility of addiction and the probability of physical dependence exist and I consent to all of these risks.
I understand that suddenly stopping this medication may result in an abstinence syndrome. I also understand that in addition to the side effects listed above, a possibility of respiratory depression and even death exists from these medications. If I feel very sleepy, I will not overtake these medications, even if my pain level or other problems are very great.
Drinking of alcohol and use of other illicit drugs while taking medications is not allowed. Medications cannot be taken in any other manner other than that prescribed.
Inappropriate or threatening behavior towards physician or staff will not be tolerated. These behaviors will be reported to proper authorities and will be cause for termination of care.
I further agree that my narcotics prescription may be stopped or decreased at any time for any reason by my physician or any other Interventional Spine Center, Inc. & Pain Management Associates, Inc. physician. I understand that violating any of the conditions of this agreement may result in dismissal from this practice. Violation of this agreement may also result I narcotics no longer being prescribed.
By signing below, I certify that I have received the opioid contract and understand the above instructions. I have read or have had explained to me all of the conditions listed in this contract. I have had a chance to ask questions and all of my questions have been answered. I fully accept the terms of this contract. I realize that if I fail to comply by the terms of this contract, I may be discharged from the pain program.

Patient Name:____ DOB: ________________________

Patient Signature:______________________________________ Date: ________________________

Interventional Spine Center,
Pain Management Associates

FINANCIAL AGREEMENT

Dear Patient:

Our Surgery center is accredited by the Accreditation Association for Ambulatory Healthcare (AAAHC).
The AAAHC is the preeminent leader in developing standards to advance and promote patient safety, quality, value, and measurement of performance for ambulatory surgery centers nationwide.
Please be informed that there are two parts to the charges for your procedures: 1) the Professional charge which is for services that your physician provides for you billed by Pain Management Associates Inc and 2) the Facility charge which covers costs of maintaining the facility, equipment, facility licenses, and accreditation of the facility billed by Interventional Spine Center Inc. Your insurance will be billed separately for these two charges. Copayments, Coinsurance, and Deductibles will apply according to your insurance plan.

Our facility is contracted with most major insurance companies and HMOs.

Be sure to receive the following from our office staff at the time of scheduling your procedure:

Signed consent for procedure(s)
Pre and Post procedure patient instructions
Patient attestation including disclosure of physician ownership.

By signing below, I acknowledge that I have read, understand, and agree with the above information.

Patient Name: ____ DOB: __________________________

Patient Signature: ____ Date: __________________________