CONSENT TO OBTAIN INFORMATION

Cedar Rapids pain associates

4205 Glass Road N.E. Cedar Rapids, Iowa 52402
Phone: 319-294-0094 Fax: 319-294-0095

Please PRINT all (except signature at bottom) and provide complete information in each section.

Patient's Legal Name_____ Date of Birth_____

By signing this form I am authorizing Advanced Spine & Rehab Center/Cedar Rapids Pain Associates to obtain medical information concerning the above named patient from the person/facility listed below.

_____
Name of Person and/or Institution requesting information from

_____ _____
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

Check the information to be disclosed (include dates where indicated): ❑Minimum necessary or specify below

- ❑ Entire Record
- ❑ Medication list
- ❑ Most recent history and physical or specify date(s)
- ❑ Clinical notes related to visit(s), specify visits or date(s)
- ❑ CD of Images (X-ray, MRI, CT), specify type and date(s)
- ❑ Report of test results (i.e. lab, X-ray, etc.), specify type and date(s)
- ❑ Billing information
- ❑ Other, specify _____

As per my request, the reason for obtaining information is:

❑ Continued medical care ❑ Legal ❑ Insurance ❑ Personal ❑ Other (specify) _____

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to Cedar Rapids Pain Associates, 4205 Glass Road N.E., Cedar Rapids, IA 52402 I understand that any release which was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized re-disclosure, and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Office Manager at the above address.

I understand that Cedar Rapids Pain Associates may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in a denial of those services.

I understand that the information to be released may include information in the following categories unless I specifically deny the release (***initial*** any category ***not*** to be released).
Substance Abuse _____ Mental Health _____ HIV-related information _____

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months) _____

_____ _____
Signature of Patient or Legal Guardian **Date**

_____ _____
Address/Street/P.O. Box City, State, Zip Code

_____ _____
Relationship, if Not the patient Witness Signature

CRPA use only:

Form Sent: _____
Name Date

Original – medical record
Copies – deliver as requested above
– to patient

CONSENT TO RELEASE INFORMATION

Cedar Rapids pain associates

4205 Glass Road N.E. Cedar Rapids, Iowa 52402
Phone: 319-294-0094 Fax: 319-294-0095

Please PRINT all (except signature at bottom) and provide complete information in each section.

Patient's Legal Name_____ Date of Birth_____

By signing this form I am authorizing Advanced Spine & Rehab Center/Cedar Rapids Pain Associates to release medical information concerning the above named patient to the person/facility listed below.

_____
Name of Person and/or Institution releasing information to

_____ _____
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

Check the information to be disclosed (include dates where indicated): ❑Minimum necessary or specify below
Entire Record

- ❑ Medication list
- ❑ Most recent history and physical or specify date(s)
- ❑ Clinical notes related to visit(s), specify visits or date(s)
- ❑ CD of Images (X-ray, MRI, CT), specify type and date(s)
- ❑ Report of test results (i.e. lab, X-ray, etc.), specify type and date(s)
- ❑ Billing information
- ❑ Other, specify _____

As per my request, the reason for release of information is:

❑ Continued medical care ❑ Legal ❑ Insurance ❑ Personal ❑ Other (specify) _____

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to Cedar Rapids Pain Associates, 4205 Glass Road N.E., Cedar Rapids, IA 52402 I understand that any release which was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized re-disclosure, and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Office Manager at the above address.

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_____ _____
Relationship, if Not the patient Witness Signature

CRPA use only:

Form Sent: _____
Name Date

Original – medical record
Copies – deliver as requested above
– to patient

Patient Authorization

CEDAR RAPIDS PAIN ASSOCIATES/ADVANCD SPINE AND REHAB CENTER FINANCIAL POLICY

As a courtesy, Cedar Rapids Pain Associates/Advanced Spine and Rehab Center will verify your insurance benefits; however, it is ultimately your responsibility to be aware of your specific coverage. We will also bill your insurer on your behalf. If your insurer designates that a copayment, deductible, and/or co-insurance is your responsibility, we are obligated to collect it. The ultimate payment responsibility is yours – you will be billed for any balance not paid by your insurance.

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION / FINANCIAL RESPONSIBILITY

I authorize my insurer to pay benefits directly to Cedar Rapids Pain Associates/Advanced Spine and Rehab Center. I authorize Cedar Rapids Pain Associates/Advanced Spine and Rehab Center to release all information necessary to secure payment including documentation on the medical record which may include present or past history of mental illness, alcohol abuse, drug abuse or HIV/AIDS related information. In understand that I am financially responsible for all charges incurred at Cedar Rapids Pain Associates/Advanced Spine and Rehab Center. Any portion of these charges not covered by my insurer must be paid by me. I further understand that copayments are due at the time of my Cedar Rapids Pain Associates/Advanced Spine and Rehab Center visit and that payment of any deductibles and coinsurance are my responsibility as stated by my contract with my insurer.

HIPAA NOTICE OF PRIVACY PRACTICES

I understand that Cedar Rapids Pain Associates/Advanced Spine and Rehab Center and its staff will make every effort to keep my protected health information confidential and private. My signature below acknowledges that: I understand that Cedar Rapids Pain Associates/Advanced Spine and Rehab Center may use and disclose my protected health information for treatment, billing to obtain payment, and for related health care operations; I have been offered a copy of, read or received Cedar Rapids Pain Associates/Advanced Spine and Rehab Center's Notice of Protected Health Information Practices (Privacy Notice); and I may obtain a copy of the Privacy Notice at any time or view it on the Cedar Rapids Pain Associates web site at www.crpainfree.com.

I have read and agree to the terms to the information stated above.

_____ _____

Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor Date

If signed by patient representative or parent/legal guardian, indicate relationship to patient_____

CONSENT FOR TREATMENT OF MINOR PARTY

In the event that I am unable to accompany my minor child (under 18 years of age) to his/her Cedar Rapids Pain Associates/Advanced Spine and Rehab Center appointments, I permit Cedar Rapids Pain Associates/Advanced Spine and Rehab Center to render treatment to my child while I am not present.

_____ _____

Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor Date

If signed by patient representative or parent/legal guardian, indicate relationship to patient_____

MEDICAL HISTORY AND CONSENT FOR TREATMENT

I certify the medical information I have provided is accurate, complete and true.

I authorize Cedar Rapids Pain Associates/Advanced Spine and Rehab Center and any associates, assistants and other health care providers it may deem necessary to treat my condition. I understand in no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

_____ _____

Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor Date

If signed by patient representative or parent/legal guardian, indicate relationship to patient_____

Cedar Rapids Pain Associates

Late Appointment Policy

At Cedar Rapids Pain Associates we strive to keep appointments on time for both our patients and providers.

In order to keep our providers on schedule and the wait time for our patients as little as possible, we do not take late appointments.

By signing this, you understand that if you are late to any appointment, you may not be seen and will need to be re-scheduled.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Statement of Nondiscrimination

English: Cedar Rapids Pain Associates complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-319-294-0094.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-319-294-0094。

Patient Name: _____ Date: _____

Surgical History

Surgery	Year

Family History – immediate family only: mother, father, siblings, children

	YES	NO	COMMENTS
Cancer	☐	☐	Type:
Diabetes	☐	☐	
Heart Disease	☐	☐	
Liver Disease	☐	☐	
Kidney Disease	☐	☐	
Stroke	☐	☐	

Medications: Please list ALL medication you take, both prescription and non-prescription OR provide us with a medication list.

Name of Medication	Dose	Frequency

Allergies: Please list drug and non-drug allergies

Drug or Allergen	Reaction

Patient Name: _____ Date: _____

Health History

Please complete the following regarding your health history. Mark all boxes that apply.

	YES	NO	COMMENTS
Asthma	☐	☐	
COPD	☐	☐	
Obstructive Sleep Apnea	☐	☐	
High Cholesterol	☐	☐	
High Blood Pressure	☐	☐	
Heart Attack	☐	☐	
Heart Disease	☐	☐	
Stroke	☐	☐	
Liver Disease	☐	☐	☐ Hepatitis ☐ Cirrhosis ☐
Kidney Disease	☐	☐	☐ Kidney Failure ☐ Stones ☐
Gastrointestinal Disease	☐	☐	☐ Ulcers ☐ Reflux ☐ Colitis ☐
Bleeding Disorders	☐	☐	
Diabetes	☐	☐	
Thyroid Disorders	☐	☐	
Rheumatoid Arthritis	☐	☐	
Osteoporosis	☐	☐	
Cancer	☐	☐	Type:
Fibromyalgia	☐	☐	
HIV/AIDS	☐	☐	
Psychiatric Disease	☐	☐	☐ Depression ☐ Anxiety ☐ Bipolar Disorder ☐ Schizophrenia ☐
Neurological Disease	☐	☐	☐ Parkinson ☐ Cerebral Palsy ☐ Seizures ☐ Neuropathy ☐ Multiple Sclerosis ☐ Migraines
Drug Abuse	☐	☐	
Alcohol Abuse	☐	☐	
Pregnant currently	☐	☐	
Other Conditions	☐	☐	Please list:

Social History

Substance	Currently use? (Please circle)	Previously used? (Please circle)	Type/Amount/Frequency	How Long? (Years)	If quit, when? (Year)
Caffeine	Yes No	Yes No			
Tobacco	Yes No	Yes No			
Alcohol	Yes No	Yes No			
Illegal drugs	Yes No	Yes No			

Patient Name: _____ Date: _____

Review of Systems

Please check all symptoms you have had regularly in the last **MONTH**:

GENERAL	YES	NO
Unexplained weight loss	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Night sweats	☐	☐

EYES	YES	NO
Eye disease or eye injury	☐	☐
Blurry vision	☐	☐
Double vision	☐	☐

EARS, NOSE, and THROAT	YES	NO
Hearing loss	☐	☐
Ringing in ears	☐	☐
Nosebleeds	☐	☐

CARDIOVASCULAR	YES	NO
Chest pain	☐	☐
Fast/irregular heartbeat	☐	☐

RESPIRATORY	YES	NO
Frequent coughing	☐	☐
Spitting up blood	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐

NEUROLOGICAL	YES	NO
Frequent or recurrent headaches	☐	☐
Light headed or dizzy	☐	☐
Convulsions or seizure	☐	☐

PSYCHIATRIC	YES	NO
Memory loss or confusion	☐	☐
Anxiety	☐	☐
Depression	☐	☐
Suicidal thoughts	☐	☐

GASTROINTESTINAL	YES	NO
Loss in appetite	☐	☐
Change in bowel movements	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Frequent diarrhea	☐	☐
Constipation	☐	☐
Stomach pain	☐	☐

GENITOURINARY	YES	NO
Frequent urination	☐	☐
Burning or painful urination	☐	☐
Incontinence	☐	☐
Date of last menstrual period	___/___/____	

MUSCULOSKELETAL	YES	NO
Muscle weakness	☐	☐
Joint pain	☐	☐
Muscle pain or cramps	☐	☐
Back pain	☐	☐
Neck pain	☐	☐

SKIN	YES	NO
Rash	☐	☐
Itching	☐	☐
Skin infection	☐	☐

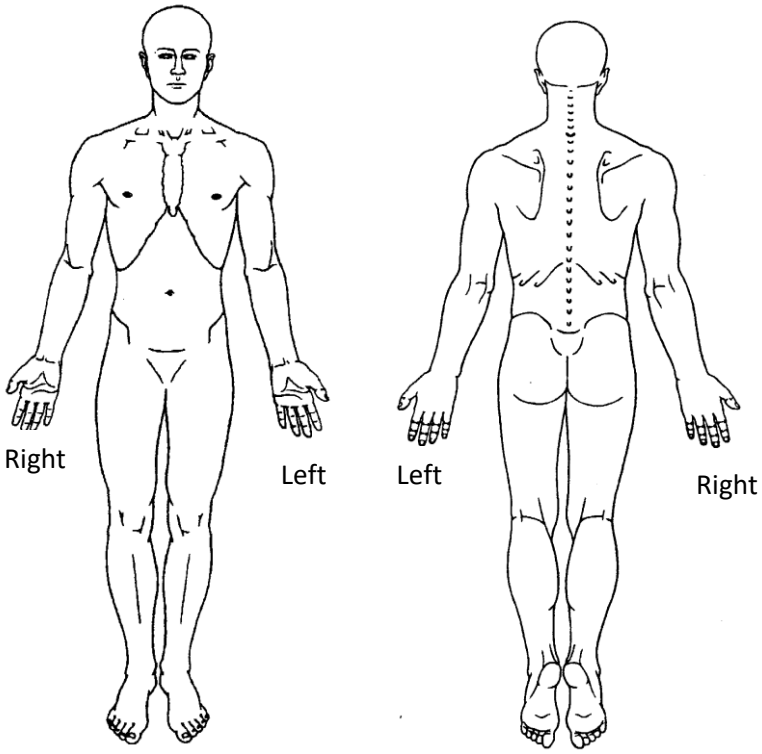
ENDOCRINE	YES	NO
Excessive thirst	☐	☐
Heat intolerance	☐	☐
Cold intolerance	☐	☐

HEMATOLOGIC	YES	NO
Easily bruise or bleed	☐	☐
Chemotherapy/radiation	☐	☐

Patient Name: _____ Date: _____

CURRENT PROBLEM

Please shade in where your primary pain is located using the diagrams below. Please keep in mind that all areas of pain may not be able to be addressed in one visit.



When did the pain begin? _____

Did it begin gradually or suddenly? _____If suddenly, is it the result of an injury? ____Yes ____No

If result of an injury, describe the injury:_____

_____

If not a result of injury, what do you think caused your pain? _____

_____

Since your pain started is it: Worse Unchanged Intermittent Better (please circle one)

Please describe your pain in as much detail as possible, including symptoms such as numbness, weakness, or pins and needles sensation.

_____

_____

What kinds of treatment have you tried for this pain? (Ex: chiropractic, physical therapy, medical equipment, medications, injections)

_____

_____