We look forward to seeing you at your appointment on _________________.

Your arrival time is ___________.

Please bring this completed paperwork, your insurance card, and a photo ID.

*****PLEASE READ INSTRUCTIONS BEFORE COMPLETING PAPERWORK*****

PAGES 1 – 4: ONLY COMPLETE THE YELLOW HIGHLIGHTED AREAS

- **The first two pages look similar but they are different**. One is to **Obtain** recordsand the other is to **Release** records. We will keep these consents on file and this allows us to obtain and release records for you upon your request.

PAGES 5 – 8: **COMPLETE ALL SECTIONS**

- **Family History** only relates to immediate family members – your mother, father,brothers, sisters, and children.
- **Medications: If you have a Medication List please bring that with you and you can skip this section.**
- **Review of Systems** includes symptoms you have had in the last 30 days (1 month).

CONSENT TO OBTAIN INFORMATION

4205 Glass Road N.E. Cedar Rapids, Iowa 52402
Phone: 319-294-0094 Fax: 844-464-3303

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)
- ❑ **REPORTS** of test results – no CD of images, 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

CONSENT TO RELEASE INFORMATION

4205 Glass Road N.E. Cedar Rapids, Iowa 52402
Phone: 319-294-0094 Fax: 844-464-3303

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 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)
- ❑ **REPORTS** of test results – no CD of images, 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.

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

Cedar Rapids Pain Associates, PC Acknowledgements and Authorizations

Release of Information to Insurance for Payment

I authorize that my insurance plan payments be paid directly to Cedar Rapids Pain Associates, PC for all services received at the clinic. I understand that I am financially responsible for any copays and/or deductibles. I also authorize Cedar Rapids Pain Associates, PC to release any information required to obtain insurance payment.

____

Patient Signature   Date Signed

Medical History Attestation and Consent for Treatment

I certify that the medical information I have provided to Cedar Rapids Pain Associates, PC is accurate, complete, and true to the best of my knowledge.
I authorize Cedar Rapids Pain Associates, PC, it's medical providers and ancillary staff to perform evaluation and treatment services as deemed necessary. All procedures will performed with separate written consent. I acknowledge that no guarantee can be made concerning my examinations, prescribed treatments, or procedures.

____

Patient Signature   Date Signed

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have been given a copy of Cedar Rapids Pain Associates, PC Notice of Privacy Practices. I understand that Cedar Rapids Pain Associates, PC is a HIPAA compliant office and I have a right to obtain a copy of the Notice of Privacy Practices upon request.

____

Patient Signature   Date Signed

Consent for Treatment of Minor Patient

In the event that I am unable to accompany my minor child (under age 18 yrs) to his/her appointment at Cedar Rapids Pain Associates, PC, I give permission to Cedar Rapids Pain Associates, PC to render treatment to my child when I am not present.

____

Patient Name   Patient DOB

____

Parent/Guardian Signature   Date Signed

Cedar Rapids Pain Associates, PC Financial Policy

Thank you for choosing Cedar Rapids Pain Associates, PC. We believe it is important that you understand our financial policy to maintain a solid professional relationship. Please carefully read and sign the following financial policy. A copy of this policy will be provided to you upon request.

Your Financial Responsibility

1. **Insurance Card:** You are responsible for bringing in a current insurance card to each appointment. We will copy this card for proper filing of your claims, if you do not have a current card contact your insurance plan to issue a new card.
2. **Insurance Benefits:** You are responsible to know your insurance plan's benefits and limitations, including copays, deductibles, exclusions and policy restrictions. We do check benefits for some procedures performed here at our office, you will be notified of what you are estimated to owe. This estimate is not a guarantee of payment from your insurance company.
3. **Copays & Deductibles:** You are responsible for paying your copay and deductible at the time of service, this arrangement is part of your insurance plan contract that you signed with your insurance company.
4. **Balances:** You are responsible for any balance that is not paid by your insurance company. Payment is due upon receipt of your statement. Any balance that remains unpaid in excess of 30 days will be sent to an account recovery company.
5. **Returned Checks:** You will be assessed a $20.00 charge each time a check is returned for non-sufficient funds.
6. **Cash Pay:** You will be responsible to pay for services at the time of service if you do not have insurance or do not have current insurance information with you.
7. **Payment Options:** We accept the following forms of payment: cash, checks, Visa, MasterCard, Discover, and Care Credit. We have guidelines we must follow but we do make every effort to work out payment arrangements upon request.

I have read and understand the financial policy and agree to abide by its guidelines:

____

Patient Signature Date signed

____

Signature of Parent of Legal Guardian if patient is a minor

Patient Name:____ Date: ____________________

CURRENT PROBLEM

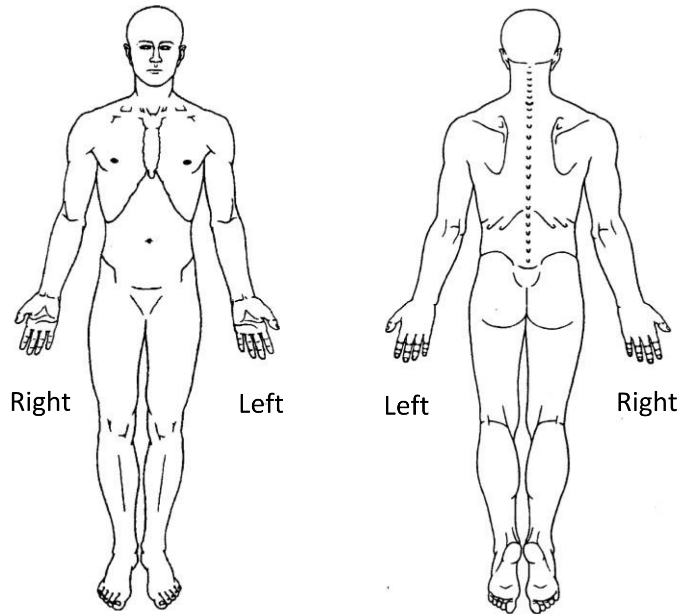
Please shade in where you have pain using the diagrams below.

What one area would you like to focus on today?

____

____

Using the area of pain you would like to focus on today, please answer the following questions.



Have you seen any other healthcare providers for this issue? Yes / No

- If yes, please list ____

When is the **FIRST** time you ever had pain in this area? ____

What do you think caused your pain? ____

Please circle the words that describe your pain:

Dull Achy Sharp Stabbing Shooting Burning Radiating

Numbness Weakness Pins & Needles Constant Intermittent Pressure

Please circle the treatments you have you tried for this pain:

Chiropractic Physical Therapy Medical Equipment (ex: TENS, Braces) Surgery

Medications: Ibuprofen Tylenol Aleve Topical Rubs Muscles Relaxants Narcotics

Other: ____

Injections: Joint Injection Epidural Trigger Point Injections Other:______________________

What is your occupation (if retired, what was your previous occupation)? ______________________________

What activities or hobbies does this pain interfere with? ____

Patient Name:____ Date: ____________________

Surgical History – All surgical procedures since birth.

Surgery	Year

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

	YES	NO	COMMENTS
Cancer	☐	☐	Type:
Diabetes	☐	☐	

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 (ex: lidocaine, iodine, chlorhexidine)

Drug or Allergen	Reaction

Patient Name:____ Date: ____________________

Health History

Are you currently, or have you previously, taken medication or been treated for ANY of the following conditions?

	YES	NO	COMMENTS
Respiratory Disease	☐	☐	☐ COPD ☐ Asthma ☐ Other
Obstructive Sleep Apnea	☐	☐	
High Blood Pressure	☐	☐	
Heart Attack / Heart Disease	☐	☐	
Stroke	☐	☐	
Liver Disease	☐	☐	☐ Hepatitis ☐ Cirrhosis ☐ HIV/AIDS ☐ Other
Kidney Disease	☐	☐	☐ Kidney Failure
Gastrointestinal Disease	☐	☐	☐ Ulcers ☐ Reflux ☐ Colitis ☐
Bleeding or Clotting Disorders	☐	☐	
Diabetes	☐	☐	☐ Insulin
Thyroid Disorders	☐	☐	☐ Hyper ☐ Hypo ☐ Hashimoto's
Arthritis	☐	☐	☐ Osteoarthritis ☐ Rheumatoid (confirmed by lab test)
Osteoporosis	☐	☐	
Cancer	☐	☐	Type: ☐ Chemotherapy ☐ Radiation
Fibromyalgia	☐	☐	
HIV/AIDS	☐	☐	
Psychiatric Disease	☐	☐	☐ Depression ☐ Anxiety ☐ Bipolar Disorder ☐ Schizophrenia ☐ PTSD
Neurological Disease	☐	☐	☐ Parkinson ☐ Cerebral Palsy ☐ Seizures ☐ Multiple Sclerosis ☐ Vertigo / Meniere's ☐ Dementia
Migraines	☐	☐	
Skin Conditions	☐	☐	☐ Lupus ☐ Psoriasis ☐ MRSA ☐ Shingles
Neuropathy	☐	☐	Areas affected:
Drug Use / Abuse	☐	☐	☐ Recovered ☐ In treatment ☐ Socially
Alcohol Use / Abuse	☐	☐	☐ Recovered ☐ In treatment ☐ Socially
Tobacco Use / Abuse	☐	☐	☐ Current smoker ☐ Former smoker, quit date Please list:
Other conditions you've seen a doctor for or have taken medication for currently or in the past.	☐	☐	

Patient Name:____ Date: ____________________

Review of Systems

IN THE LAST MONTH - Have you experienced any of the following symptoms?

GENERAL	YES	NO
Unexplained weight loss		
Fever		
Fatigue		
EYES	**YES**	**NO**
Sudden change of vision		
CARDIOVASCULAR	**YES**	**NO**
Chest pain		
Fast or irregular heartbeat		
RESPIRATORY	**YES**	**NO**
Coughing up blood		
Shortness of breath		
NEUROLOGICAL	**YES**	**NO**
Frequent headaches		
Lightheaded or dizzy		
PSYCHIATRIC	**YES**	**NO**
Anxiety		
Depression		
GASTROINTESTINAL	**YES**	**NO**
Sudden or complete loss of bowel control		
GENITOURINARY	**YES**	**NO**
Sudden loss of bladder control		
Unable to urinate		
SKIN	**YES**	**NO**
Rash		
Skin infection		
MUSCULOSKELETAL	**YES**	**NO**
Muscle weakness		
Joint pain (If yes, list where)		
Muscle pain or cramps		
Back pain		
Neck Pain		

Cedar Rapids Pain Associates, PC Notice of Privacy Practices
Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record: You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information: You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission: Marketing purposes, sale of your information, most sharing of psychotherapy notes.

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you: We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues: We can share health information about you for certain situations such as: Preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research: We can use or share your information for health research.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you: For workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective date: 08/17/2022

Privacy Officer: Rochelle, Office Manager, 4205 Glass Rd NE Cedar Rapids IA 52402. Phone 319-294-0094. Fax 844-464-3303. Email info@crpainfree.com.

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Cedar Rapids Pain Associates, PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Cedar Rapids Pain Associates, PC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

Cedar Rapids Pain Associates, PC: Provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters. Written information in other formats (large print, audio, accessible electronic formats, other formats). Provides free language services to people whose primary language is not English, such as: Qualified interpreters. Information written in other languages If you need these services, contact our office manager, Rochelle.

If you believe that Cedar Rapids Pain Associates, PC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with: Rochelle, Office Manager, Cedar Rapids Pain Associates, PC 4205 Glass Rd NE Cedar Rapids IA 52402. Phone 319-294-0094. Fax 844-464-3303. Email info@crpainfree.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Rochelle, Office Manager, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue SW Room 509F HHH Building Washington, D.C. 20201. Phone 1-800-368-1019, 800-537-7697 (TDD).
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Limited English Proficiency of Language Assistance Services

ATTENTION: If you speak another language other than English, language assistance services, free of charge, are available to you. Call 1-319-294-0094.

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

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-319-294-0094.

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-319-294-0094.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-319-294-0094.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-319-294-0094 (رقم

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-319-294-0094.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-319-294-0094 번으로 전화해 주십시오.

ध ्यान द�: य�द आप �हदी बोलते ह � तो आपके िलए मुफ्त म� भाषा सहायता सेवाएं उपलब्ध ह।� 1-319-294-0094.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-319-294-0094.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-319-294-0094.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการชวยเหลือทางภาษาได้ฟรี โทร 1-319-294-0094.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-319-294-0094.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-319-294-0094.