Applied Pain Institute LLC

1015 S. Mercer Avenue
Bloomington, IL 61701

Today's Date:_____ Email Address:_____

Printed Name: _____ Date of Birth: _____

Age:_____ Gender: (circle) M F SSN: _____

Street Address: _____ PO Box: _____

City: _____ State/Zip: _____

Married _____ Single _____ Widowed _____ Divorced _____

Home Phone:_____ Cell Phone: _____

Employer: _____ Work Phone: _____

Work Address:_____ City/State/Zip: _____

Primary Insurance:

Insured's Name: _____
(last) (first) (middle initial)

Insured's birth date: _____ Relationship to patient: _____

Address (if different from patient): _____ PO Box_____

City:_____ State/Zip: _____ Phone: _____

Insured's Employer:_____ Occupation: _____

Work Address: _____ Work Phone:_____

Insurance Company: _____

Secondary Insurance:

Insured's Name: _____
(last) (first) (middle initial)

Insured's birth date: _____ Relationship to patient: _____

Address (if different from patient): _____ PO Box_____

City:_____ State/Zip: _____ Phone: _____

Insured's Employer:_____ Occupation: _____

Work Address: _____ Work Phone:_____

Insurance Company: _____

 ALL sections are REQUIRED to be COMPLETED

Worker's Compensation:

Please ask the front desk staff for our Worker's Compensation form. Complete all sections.

You must provide all claim information prior to being seen.

We must receive written authorization from your Worker's Compensation Insurance before providing treatment. You or your attorney may be required to help obtain this authorization.

Auto Accidents and Personal Liability Claims:

All Auto Accident and Personal Liability Claims are subject to Lien for Payment.

You must provide all claim information before being seen.

Date of accident/injury: _____

Select type of claim:

___ Non-auto (personal liability) claim ___ Auto (At-Fault Driver) ___ Auto (Other driver At-Fault)

For Auto Claims:

Your Auto Insurance Company _____

Your Claim number _____

Name of Your Insurance Company's Claim Adjustor_____

Other Driver's Name _____

Other Driver's Auto Insurance Company_____

Name of Other Driver's Claim Adjustor_____

Name of Attorney _____ Attorney ph # _____

For Non-auto Claims:

Name of Insurance Company

_____

Name/ph # of Responsible Party

_____

Name of Attorney _____ Attorney ph #

_____

For all Worker's Compensation, Auto Accident and Personal Liability Claims:

You are required to provide

1. Regular (commercial, group or individual) health insurance cards
2. Legal photo identification such as State ID or Driver's License.

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Medication and Treatment Agreement

By signing, the patient agrees to follow the guidelines as stated.

- Patients MUST maintain a working relationship with their Primary Care Physician and notify us of changes. **Primary care physician:** _____
- address:_____ phone:_____
- Patients receiving ANY MEDICATIONS including barbiturates, opiates, or benzodiazepines (example: Percocet, morphine, Demerol, Methadone, Duragesic, Oxycodone, Dilaudid, Codeine, Ativan, Xanax, or similar generic forms) agree to follow the prescription label instruction, using the medication ONLY AS PRESCRIBED.
- Taking pain medication other than what Dr. Li prescribes or more often than directed is prohibited.
- Prescriptions for the medications listed above will be written for a maximum of one month. All patients receiving these medications are required to be seen in the office once a month unless otherwise documented in the patient chart by Dr. Ji Li.
- Medications listed above may require paper prescriptions. In an emergency, these medications can be dispensed over the phone at the discretion of Dr. Ji Li. If Dr. Ji Li deems the situation an emergency, a limited three-day supply may be allowed. This provides an adequate supply of medication until the patient can be seen in the office for an evaluation.
- Patients are REQUIRED to use only ONE PHARMACY. **Designated Pharmacy:**_____
- Patients are expected to be responsible for the safety of their medications. Inappropriate use, tampering, accidental destruction, loss or theft of medication is unacceptable. Sharing with or selling prescription medication to other persons is illegal.
- Medications WILL NOT be replaced or refilled early – NO EXCEPTIONS, NO EXCUSES.
- Refills will be issued only one day before the due date – no earlier. If you need a paper prescription early due to travel you may request to pick it up prior to leaving; however, it will be dated for when it is actually due – lost or stolen prescriptions cannot be replaced. Dr. Ji Li reserves the right to limit the number of "travel prescriptions".
- Patients will not request or accept pain medications from physicians other than Dr. Ji Li. By receiving medications from a single provider, the risk of drug interactions and excessive doses can be prevented. We reserve the right to periodically search the Illinois Prescription Library or contact your pharmacy for your prescription medication history.
- Patients will not receive return phone calls for medication refills. Please allow 1 - 2 BUSINESS DAYS for refills to be called to your pharmacy then check with your pharmacy for the status of the refill. This minimizes interruptions during clinic hours for the benefit of all patients.
- Patients are expected to comply with all components of the treatment plan, including but not limited to physical therapy, psychology (biofeedback, etc.), drug screens by urine or blood to detect prescription and illicit drug, and referrals to other physicians or healthcare practitioners.
- We reserve the right to limit or suspend treatment and/or medication refills for patients with delinquent financial accounts until the account is paid in full or payment arrangements are made.
- Non-adherence to any of these statements will be considered a breach of this agreement and may result in termination of medication or other treatment, or discharge from all services by Dr. Ji Li and Applied Pain Institute, LLC.
- Your signature below indicates that you have read and understand these policies.

Patient Signature: _____ **Date:** _____

Signature/Description of Personal Representative's Authority _____

A copy of this signed treatment agreement will be provided to the patient at the patient's request.

ALL sections are REQUIRED to be COMPLETED

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Financial Agreement / Assignment of Benefits / Release of Records

Forms: There is a $25.00 fee for completing each of the following forms. This fee is due when the form is submitted – forms are not completed until payment is received.

Disability Insurance ~ Leave of Absence ~ Family Medical Leave Act (FMLA)

This office does not complete Certification for Permanent Disability or Financial Hardship forms. Please direct these forms to your primary care physician.

Late Cancellation/Missed Appointments: Late cancellations and missed appointments impact everyone. A $35.00 fee is charged for appointments missed without 24 hours notice. This fee cannot be billed to insurance and is the responsibility of the patient. This fee is subject to collections if not paid within 60 days. The building closes when Unit 5/District 87 Schools close for weather – fee does not apply to these closures.

Non-sufficient funds/Returned Checks: Checks returned for insufficient funds (NSF) will result in a $25.00 service fee in addition to the original billed amount. Please make payment arrangements with our billing staff to prevent incurring additional fees.

Collections and Interest Owed: If your outstanding balance is more than you can afford within the first 60 days please make payment arrangements with our billing staff before you incur additional fees and interest owed, as well as risking damage to your credit record. A Collections Fee of $100 will be added to accounts turned over.

Every effort is made to bill insurance accurately and in accordance with insurance timely filing rules; however, it is ultimately the patient's responsibility to pay for services rendered. Additionally, it is the patient's responsibility to notify this office of any change in insurance coverage. I understand that this office bills for reimbursement from my insurer or other third party payer as a courtesy. Failure on the part of the insurer to make payment shall not relieve me of my obligation to pay for services rendered. Once insurance makes a determination, all outstanding balances are patient responsibility to the extent allowed by law and by contractual agreements with the insuring entity. This balance is due within 60 days. Account balances that are 60 days past due may bear interest on the unpaid amount up to the maximum allowed by law and will be sent to collections. Collection fees and attorney fees are in addition to the outstanding balance and are the responsibility of the patient. I hereby waive all claims of exemption. Should the account be referred to an attorney, I shall pay reasonable attorney and associated collection expenses regardless of whether suit is filed.

Insurance Assignment of Benefits and Release of Medical Information: I assign all insurance benefits (Medicare, Medicaid, group or private commercial insurance, Worker's Compensation) to be paid directly to Applied Pain Institute, LLC for services rendered. A photocopy of this agreement shall be valid as the original.

I authorize the use of my signature below for all insurance submissions. I authorize Applied Pain Institute, LLC (physicians, staff, other HIPAA authorized agents) to disclose my protected health information (medical and financial records) for the purposes of determining insurance benefit eligibility and preauthorization/ predetermination, obtaining benefit payment, and/or discussing disputed payments related to services rendered. I further agree to allow my protected health information to be released to (a) any affiliate and its employees and agents for continuation of care; (b) any person or entity responsible for all or part of continuation of care rendered at a hospital or ambulatory surgical center; (c) any person or entity to whom I have been referred for continuing care; (d) any physician treating, consulting, or otherwise performing services for me, including his or her employees or agents; (e) the Health Care Financing Administration, any government or accrediting agency, or their agents or employees.

I understand I am financially responsible for all charges regardless of insurance payment (co-pay, deductible, excluded for any reason, or otherwise denied to the extent not expressly prohibited by law or by the contract between the provider and my third party payer).

Your signature below indicates that you have read and understand these policies.

_____ _____

Signature of patient/authorized representative Date

FINANCIAL AGREEMENT – READ BEFORE SIGNING

Applied Pain Institute, LLC
1015 S. Mercer Avenue
Bloomington, IL 61701

I acknowledge I was offered a Notice of Privacy Practices from Applied Pain Institute, LLC.

I understand my personal health information may be exchanged between Applied Pain Institute, LLC, and my primary care physician, as well as other physicians involved in my care and insurance companies involved paying for in my care during the current calendar year (January 1 to December 31). I understand I may stop the release of information at any time by notifying Applied Pain Institute, LLC in writing as outlined in the Notice of Privacy Practices.

Staff will attempt to speak directly with you about your healthcare needs; however, if we are unable to reach you, your signature below indicates you agree to allow us to leave a voice message for you at the phone numbers which you have provided to us. Additionally, with your signed permission below, we may communicate with your family members or other designated persons about your appointments and your health care issues.

Initial here to grant permission for voice messages: Yes _____ No _____

Initial here to grant permission for communication with others: Yes _____ No _____

Please list the contact information for any designated persons:

Name	Relationship	Phone number
Name	Relationship	Phone number

Print name of patient/authorized representative _____ Date of Birth _____

Signature of patient/authorized representative _____ Date _____

If Personal Representative's signature appears above for either of these designations, please indicate relationship to patient and provide a copy of legal authority to act on patient's behalf.

Relationship (POAH, Guardian, Custodian, etc.) _____

ALL sections are REQUIRED to be COMPLETED

Pain Assessment Form

Name: _____ Today's Date: _____

Birth date: _____ Age:_____ Ht:_____ Wt: _____

Referring Provider: _____ Primary Care Physician: _____

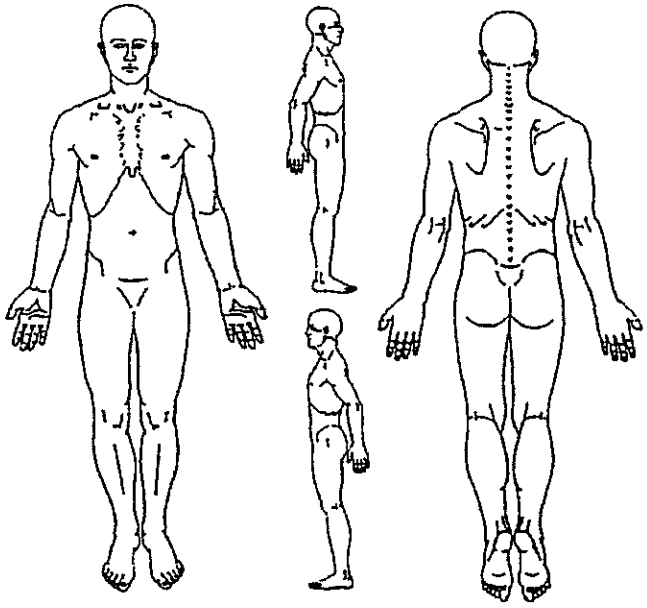
What problem would you like us to help you with?

Please mark and date the event or events which led to your present pain:

Date		Description
_____	Accident	_____
_____	Injury	_____
_____	Following surgery	_____
_____	Cancer	_____
_____	Other disease	_____
_____	No obvious cause	_____

Using the figure below, please indicate the location and type of pain you experience:

AAA = Ache NNN = Numb OOO = Pins/Needles XXX = burning /// = stabbing



ALL sections are REQUIRED to be COMPLETED

Please list all medications you currently take:

Medications	Dose (milligrams)	Frequency (instructions)	How long used

Are you currently taking Coumadin or other blood thinners Yes ____ No _____

Are you currently taking any benzodiazepines (xanax, valium, etc.) Yes _____ No _____

Are you allergic to any foods or medications (list) _____

Are you allergic to tape or latex _____

Do you or have you used tobacco Yes _____ No _____ If yes, packs per day _____

Do you or have you used alcohol Yes _____ No _____ If yes, drinks per day _____

Do you or have you used street drugs (list) _____

What is your current employment status _____

Do you have a pending settlement for disability, worker's compensation, or other legal matters – if yes, please briefly describe:

List your other physicians and their specialties (e.g. orthopedic, surgeon, neurologist, etc.)

List all surgeries you've had and their corresponding dates:

List all MRI's, CT Scans or X-rays you've had and their corresponding dates:

What do you think causes this pain?

How long have you had this pain?

What makes your pain better?

What makes your pain worse?

Does the pain interrupt your sleep?

Do you have trouble with bladder or bowel control?

Please circle any medical conditions you have been treated for:

high blood pressure	angina	heart attack	bleeding disease
mitral valve prolapse	pacemaker	COPD	HIV / AIDS
emphysema	asthma	bronchitis	shingles
ulcer disease	hepatitis	cirrhosis	seizure disorder
kidney disease	cancer	diabetes	osteoporosis
thyroid disease	arthritis	other _____	

How often does the pain occur?

_____ Continually (non-stop)
_____ Several times a day
_____ Once or twice a day
_____ Several time a week
_____ Less than 3-4 times a month

Does the pain affect your activity in these areas?

_____ School
_____ Work
_____ Leisure
_____ Household chores
_____ Social Interaction
_____ Sexual Activity
Other _____

ALL sections are REQUIRED to be COMPLETED

Circle the words that describe your pain (use as many as you need)

dull ache sharp stabbing shooting crushing/squeezing cramping

gnawing electric stinging burning prickling/tingling numb

Circle the one number that describes your pain at its WORST in the last 24 hours:

0 1 2 3 4 5 6 7 8 9 10
no pain worst

Circle the one number that describes your pain at its LEAST in the last 24 hours:

0 1 2 3 4 5 6 7 8 9 10
no pain worst

Circle the one number that describes your pain at its overall AVERAGE:

0 1 2 3 4 5 6 7 8 9 10
no pain worst

Circle the one number that describes your pain RIGHT NOW:

0 1 2 3 4 5 6 7 8 9 10
no pain worst

Mark the treatments you've tried. What helps? For how long? What are you currently using?

Treatment Tried	Dates	No Help	Some Help	Great Help	How Long
Surgery					
Nerve blocks					
Radio frequency ablation					
Epidural injection					
Trigger point injection					
Physical Therapy					
TENS unit					
Chiropractic Therapy					
Exercises at home or gym					
Braces/splints					
Acupuncture					
Massage					
Psychological counseling					
Biofeedback					
Hypnosis					
Other:					

Mark all medications you have tried. Did it help? For how long? Currently using?

Medication	No help	Some help	Great help	How long	Now taking	Dose
Acetaminophen (Tylenol)						
Amitriptyline (Elavil)						
Aspirin						
Baclofen						
Butorphanol (Stadol)						
Carbamazepine (Tegretol)						
Carisoprodol (Soma)						
Clonazepam (Klonopin)						
Codeine						
Cyclobenzaprine (Flexeril)						
Desipramine (Norpramine)						
Diazepam (Valium)						
Fentanyl (Duragesic)						
Fuloxetine (Prozac)						
Gabapentin (Neruontin)						
Haloperidol (Haldol)						
Hydrocodone (Norco)						
Hydromorphone (Dilaudid)						
Ibuprofen (Motrin, Advil)						
Ketorolac (Toradol)						
Lorazepam (Ativan)						
Meperidine (Demerol)						
Metaxalone (Skelaxin)						
Methadone						
Methocarbamol (Robaxin)						
Morphine						
MS Contin						
Nabumetone (Relafen)						
Naproxen (Naprosyn)						
Nortriptyline (Pamelor)						
Oxycodone (Percocet)						
Oxycontin						
Pentazoncine (Talwin)						
Phentoin (Dilantin)						
Promethazine (Phenergan)						
Propoxyphene (Darvon)						
Tizanidine (Zanaflex)						
Trilisate						
Tylenol with Codiene						
Others:						

ALL sections are REQUIRED to be COMPLETED