

Dear _____

Welcome to Indiana Neurology & Pain Center, We would like to thank you for the opportunity to work with you and selecting Indiana Neurology & Pain Center for your care. We want to make your experience with us as comfortable and convenient as possible by providing you with the best care we can.

The welcome packet we have includes contains some forms that we would like to have filled out **before** you arrive for your New patient Appointment. Please fill out the forms by printing only in blue or black ink. This will assist us in getting you back to see the doctor on time as well as providing a courtesy to others who may be arriving after you.

Please come prepared with ALL the following information:

- **Valid Driver license** or other form of photo identification.
- **Health insurance cards:** Bring your current health insurance card (s). In addition, your health plan requires a referral, we must have a copy in our office at the time of your visit, otherwise you will be asked to pay for your visit up front. If for some reason your referral does not arrive, you are free to reschedule your appointment.
- **Copays:** Bring any co-pays that you may have or if you are a self-pay patient, all money are due at the time of appointment. We accept cash, check, Mastercard, and Visa as forms of payment.
- **Medication List:** A list of all medications you are currently taken, please include vitamins (name of medicine, dose and amount taken per day).
- **Previous X-rays, Lab work or Scans** that have been completed within the last 6 months.
- If this visit pertains to on-the-job injury, Workers Comp or Motor Vehicle Accident, please bring any relevant information with you.

PLEASE ARRIVE AT:

Monday

Tuesday

Wednesday

Thursday

Friday

Date: _____ Arrival Time: _____ AM/PM

With the packet filled out completely. If not filled out, you can be rescheduled.

Mustafa Qureshi, MD

INPC EAST

7301 North Shadeland Ave, Suite 1-A
Indianapolis, IN 46250
Phone: 317-939-6100
Fax: 317-680-8222

NEW PATIENT REGISTRATION FORM

(Please fill Completely)

General Information

First Name _____

Last Name _____

Middle Name _____

DOB _____

Social Security _____

Marital Status S M D W Gender: M F

Address: _____

City _____ ZIP: _____

State _____

Home Phone _____ Cell Phone: _____

Work Phone _____

Race _____

Language _____ Religion: _____

Email _____

Emergency contact _____ Phone: _____

Relationship with Patient _____

Primary Care Physician _____

PCP Number _____

Insurance (You must have insurance cards with you at every visit)

Primary Insurance _____ Policy No _____ Insurance Holder _____

Spouse Name _____ DOB _____ Social Security No _____

Secondary Insurance _____ Policy No _____ Insurance Holder _____

Spouse Name _____ DOB _____ Social Security No _____

Please list Provider's you have seen in past

_____	_____	_____
Name of Physician	Start & End Date	Reason of Leaving
_____	_____	_____
Name of Physician	Start & End Date	Reason of Leaving
_____	_____	_____
Name of Physician	Start & End Date	Reason of Leaving

Past Medical History

Please circle any of the problems you have or have had

- | | | |
|---------------------|----------------------|-------------------------|
| High blood pressure | Diabetes | UTI (Urinary Infection) |
| Heart Attack | Arthritis | CAD (heart disease) |
| Asthma | COPD | GERD (Heart Burn) |
| Tuberculosis | PUD (Peptic Ulcer) | Hepatitis |
| Headache/Migraine | Seizure | Stroke/Mini Stroke |
| Memory Loss | Dementia | OSA (Sleep Apnea) |
| Bleeding Disorder | Urinary Incontinence | Cancer |
| Constipation | Prostate Problems | Thyroid Disease |
| Kidney Stone | Gall Stones | Depression |
| Swelling | Sight Problems | Hearing Problems |

Other Issues _____

Mental Health Intake Form

Please complete all information on this form and bring it to the first visit.

Name: _____ **Date:** _____

Date of Birth: _____

Primary Care Physician: _____

Permission for updates to be provided to PCP? () Yes () No [Tick one]

Current Therapist/Counselor: _____ **Phone:** _____

Problems for which you are seeking help:

1. _____

2. _____

3. _____

Treatment goals: _____

Current Symptoms Checklist

Check symptoms once if present, twice for major symptoms:

- () Depressed mood () Racing thoughts () Excessive worry
- () Unable to enjoy activities () Impulsivity () Anxiety attacks
- () Sleep disturbance () Increased risky behavior () Avoidance
- () Loss of interest () Increased libido () Hallucinations
- () Concentration issues () Decreased need for sleep () Suspiciousness
- () Appetite changes () Excessive energy () _____
- () Fatigue () Irritability () _____
- () Decreased libido () Crying spells () _____

Suicide Risk Assessment

Have you had thoughts of not wanting to live? () Yes () No

If yes:

Do you currently feel this way? () Yes () No

How often? _____

Last time you felt this way: _____

Recent events contributing? _____

Desire to harm yourself (1-10): _____

Would anything help? _____

Methods considered? _____

Access to means? _____

Plan? _____

Anything stopping you? _____

Hopeless or worthless feelings? () Yes () No

Past attempts? () Yes () No

Access to guns? Explain: _____

Past Medical History

Allergies: _____

Current Weight: _____ Height: _____

List ALL prescription medications:

Medication | Dose | Frequency | Start Date

OTC medications/supplements:

Current medical problems:

Past hospitalizations / surgeries:

EKG history: () Yes () No If yes: _____

Result: () Normal () Abnormal () Unknown

Women only:

Last menstrual period: _____

Currently pregnant? () Yes () No

Planning pregnancy? () Yes () No

Birth control: _____

Pregnancies: _____ Live births: _____

Other physical health concerns:

Past Psychiatric Medications

List dates, dosages, and response/side effects for any taken:

Antidepressants:

Prozac _____

Zoloft _____

Lexapro _____

Effexor _____

Cymbalta _____

Wellbutrin _____

Remeron _____

Other: _____

Mood Stabilizers:

Tegretol _____

Lithium _____

Depakote _____

Lamictal _____

Topamax _____

Other: _____

Additional Psychiatric Medications

Antipsychotics:

Seroquel _____

Zyprexa _____

Geodon _____

Abilify _____

Risperdal _____

Other: _____

Sedatives/Hypnotics:

Ambien _____

Sonata _____

Restoril _____

Other: _____

ADHD medications:

Adderall _____

Ritalin _____

Strattera _____

Antianxiety:

Xanax _____

Ativan _____

Valium _____

Buspar _____

Other: _____

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder () Yes () No

Depression () Yes () No

Anxiety () Yes () No

PTSD () Yes () No

Schizophrenia () Yes () No

Alcohol/Substance abuse () Yes () No

Violence () Yes () No

If yes, who: _____

Substance Use History

Treated for alcohol/drug abuse? () Yes () No

Substances used: _____

Where/when treated: _____

Alcohol:

Days/week drank: _____

Max drinks/day: _____

Most in 3 months: _____

Caffeine:

Coffee _____ Soda _____ Tea _____

Tobacco:

Ever smoked? () Yes () No

Currently? () Yes () No

Packs/day: _____ Years: _____

Quit date: _____

Other substances tried (list type, age, duration):

Trauma History

History of emotional, physical, sexual abuse, or neglect?

() Yes () No

If yes, describe when, where, and by whom:

Education & Occupation

Highest grade completed: _____

College: Where? _____ Major? _____

Current status:

Working Student Unemployed

Disabled Retired

Occupation: _____

Workplace: _____

Military service? Yes No Branch: _____

Honorable discharge? Yes No

Relationship & Family

Current status:

Married Partnered Divorced Single Widowed

Relationship? Yes No Duration: _____

Sexually active? Yes No

Sexual orientation:

Straight Gay/Lesbian Bisexual Transgender

Asexual Unsure Prefer not to answer

Children? Yes No Ages: _____

Relationship with significant other:

Relationship with children:

People living with you:

Legal & Spiritual History

Legal:

Ever arrested? _____

Pending legal issues? _____

Spiritual:

Belong to a religion/spiritual group? () Yes () No

Level of involvement: _____

Involvement is: () Helpful () Stressful

Anything else you'd like us to know?

Signature

Patient Signature: _____ Date: _____

Guardian (if minor): _____ Date: _____

Emergency Contact: _____ Phone: _____

For Office Use Only:

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996(HIPAA). I understand that by signing the consent I authorize you to use and disclose my protected health information.

1. To share it with other professionals who are treating me
2. To share my health information to manage and improve your care and contact me when necessary.
3. To share my health information to bill and receive payment from health plans and other entities.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosure of my protected health information and my rights under HIPPA.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

INDIANA NEUROLOGY AND PAIN CENTER (INPC)

3850 Shore Drive, SUITE 203
INDIANAPOLIS, IN 46254
PHONE# 317-939-6100
FAX# 317-343-4600

- Please check if you received a brochure regarding your rights and our responsibilities

Date: _____

Print Patient Name: _____

Signature: _____

Witness: _____

PATIENT AUTHORIZATION

I authorize the disclosure of any appointments and medical information as described below:

*Who is authorized to receive your health information

*Who is authorized to pick up prescriptions/samples

*Can we leave a message for you regarding your appointments

YES _____ **NO** _____

I have been informed that I don't have to sign and that will not prevent me from receiving medical care.

I understand that I may revoke this authorization in writing at any time to INPC. This authorization expires in ONE calendar year.

Patient/Representative Signature & date

Relationship to Patient

Print Name

Witness & Date

INDIANA NEUROLOGY & PAIN CENTER PROCEDURE, CANCELLATION & NO-SHOW POLICY

If you are scheduled for a procedure or an office visit and you are unable to keep your appointment, you are required to give our office a **24-hour notice** so that we can adjust our office schedule accordingly.

FAILURE to give us appropriate notice will result in a
\$25.00

CANCELLATION FEE BEING APPLIED TO YOUR ACCOUNT.

Your signature below will be an indication that you have read and understand this policy.

Sign and date

Witness

Atlas Fee Addition Disclosure:

In Consideration of the services to be provided to the customer/Patient, I/We hereby guarantee payment in full of the customer's account in accordance with the financial arrangements made at the time of service /purchase or, if no such arrangements are made, in event of default in payment, reasonable collection agency fees equal to 30% of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account, plus any applicable court cost.

Signature: _____ Date: _____

Consent Disclosure:

I expressly consent and agree that atlas services, Inc., its affiliates, agents, and providers, may use any written, electronic, or verbal means to contact me on the call phone number that I provided by calling or texting, including use of an autodial program or by an artificial or Pre-Recorded voice, or by email at address I provide. These calls, texts or email may be to deliver billing or account information, surveys, or other business- related reasons. The Provisions of services is not conditioned upon this consent, and I understand that I revoke the consent at any time by providing written notice.

Signature: _____ Date: _____

PRESCRIPTION REFILL POLICY

Medication refill requests must be made a week before your prescription is out. You may leave a message on the nurse's line and allow 48-72 hours for us to address the request.

Please allow 5-7 business days to get Prior Authorization (PA) approval on controlled medications. The duration of PA approvals depends on your insurance carrier.

Quantity of medication dispensed is determined by appointment date and discretion of the provider.

Name (print): _____

Signature: _____ **Date:** _____

Witness: _____

SOAPP Version 1.0-SF

Name: _____ Date _____

The following are some questions given to all patients who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answer alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0=Never, 1-Seldom, 2-Sometimes, 3=Often, 4=Very Often

- | | | | | | |
|--|---|---|---|---|---|
| 1. How often do you have mood swings? | 0 | 1 | 2 | 3 | 4 |
| 2. How often do you smoke a cigarette within an hour after you wake up? | 0 | 1 | 2 | 3 | 4 |
| 3. How often have you taken medication other than the way that it was prescribed? | 0 | 1 | 2 | 3 | 4 |
| 4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? | 0 | 1 | 2 | 3 | 4 |
| 5. How often, in your lifetime, have you had legal problems or been arrested? | 0 | 1 | 2 | 3 | 4 |

Please add the circled values from the right column and enter the total here →→

Please include any information you wish about the above answers. Thank you.

Opioid Contract

Please INITIAL next to each statement:

1. ___ I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy, behavioral medicine, and other pain control strategies. I agree to actively participate in all aspects of the pain management program to maximize function and improve coping with my condition. I understand that I have the right to refuse recommendations, but that does not mean that my provider must continue to prescribe narcotic or opioid medications.
2. ___ Regular follow up appointments must be made and kept as deemed appropriate by the physician. Appointments will be made every 4 weeks. Exceptions will be approved by the providers only.
3. ___ I will communicate fully with the physician about the character and intensity of my pain, the effect of the pain during daily activities, and how effective the prescribed pain medication is in treating my condition.
4. ___ I agree to give accurate and complete health information regarding past illnesses, hospitalization, medications, allergies, and other pertinent information. You must inform us of any significant changes in your condition or medications as they may affect your course care.
5. ___ I will inform the clinic 24-72 hours when I cannot keep an appointment and when I need a refill on my medication. It is my responsibility to comply the developed care plan, read education material given to me, and to adhere to the instructions given. I will ask for additional information if I do not understand something.
6. ___ I will inform the clinic of any changes in residence and/or telephone number.
7. ___ I understand and agree that my prescribed pain medication will not be refilled earlier than scheduled.
8. ___ I will not sell, share, or trade my prescribed pain medication with anyone, regardless of the situation. I will not FLUSH OR THROW away any pain medication; if I require a change in controlled medication, I am required to bring any/all of my previously prescribed pain medication back to the physician's office before receiving a new prescription.
9. ___ I agree to use the providers at INPC only to obtain any/all controlled pain medication. If I choose to use another physician and I have established a doctor/patient relationship prior, then I may continue to do so as long as I communicate this to providers at INPC as I clearly understand I will receive pain medication from just ONE doctor. If I do not do so, then I may be subject to immediate dismissal by my physician.
10. ___ I will safeguard my controlled pain medication from LOSS or THEFT. I understand that lost, dropped, or stolen controlled pain medication will not be refilled until the due date.
11. ___ I agree not to use any illegal substances. I agree to submit to a drug test at the physician's request. Presence of unauthorized substances may prompt a referral for an assessment for addictive behavior and/or termination from the practice.
12. ___ I agree to come in on the day my physician calls for a pill count, so pain medication can be counted and documented in my chart by two licensed clinic personnel; the medication MUST be in the original bottle. Refusal will result in termination.

13. ___ I authorize providers at INPC and my pharmacy to fully cooperate with any city, state, or federal law enforcement agency. This includes that Indiana's Board of Pharmacy in the investigation of any possible misuse, sale or other diversion of my prescribes controlled pain medication(s).
14. ___ I authorize INPC to provide a copy of this agreement to my pharmacy as well as to investigate my history of controlled pain medication use.
15. ___ All controlled substances must be obtained at the same pharmacy, when possible. Should the need arise to change pharmacies, our office must be notified. Pharmacy change is allowed at the time of appointment. Medications will not be sent to multiple pharmacies.
16. ___ PHARMACY INFORMATION:

17. ___ I agree to bring all unused/left over controlled pain medication(s) to every office visit. The medication MUST be in the original bottle.
18. ___ I agree to follow these guidelines that have been fully explained to me. I have been given chance to have all my questions/concerns answered and addressed adequately. I understand that a copy of this agreement is available to me at any time, upon my request.
19. ___ I understand that if I fail to comply with any of the terms of this agreement, alternative pain management options can be considered if providers opt to no longer prescribe opiate medications. I also understand that with this failure I may be discharged from this practice at any time.
20. ___ I clearly understand I will not use any leftover medications from ANY previous prescriptions. If I do so, then I may be subject to immediate dismissal by INPC/Providers at INPC.
21. ___ I clearly understand that illicit substances such as THC, Cocaine, Methamphetamine and all other "Street Drugs" including alcohol are a violation of the contract and can result in termination from INPC.
22. ___ I understand the risk of driving and operating machinery while under the influence of Opioids.
23. ___ "Females Only" I understand and agree that in the event I am/become pregnant, I will notify my physician. I understand he/she will discontinue any narcotics at this time.
24. ___ Rx for Narcan for accidental overdose may be sent to pharmacy.
25. ___ I Understand inappropriate conduct and behavior with clinical staff or providers can result in termination from INPC.

This agreement is entered on:

Print Name of Patient

Patient Signature

Date

Physician Signature

OPIOID GUIDELINES

According to ASIPP multiple reviews have shown a consistent lack of effectiveness in opioids in reducing pain and improving functional status. A cost analysis of chronic pain suggested that treatment with medications alone did not significantly improve a patient's ability to stand, sit, walk, travel, socialize, and work both in and out of the home. However, complementary treatment components, such as anesthetic procedures, physical therapy, group education, and cognitive behavioral psychotherapy, seemed to directly affect patients' pain-related functional impairments.

ASIPP recommended the follow, based on the review of multiple systematic reviews and the available literature, the recommendation is 2A weak recommendation, high-quality evidence with benefits closely balanced with risks and burden; derived from RCT's without important limitations or overwhelming evidence from observational studies; with the implication that with a weak recommendation, best action may differ depending on circumstances or patients' or societal values. Following are the principles being used in our practice to prescribe opioids recommended by ASIPP and Washing State Agency Medical Directors Group:

1. Single prescriber.
2. Single pharmacy
3. Patient and prescriber sign opioid agreement.
4. Lowest possible effective does should be used.
5. Cautious use of opioids with conditions that may be potentiate opioid adverse effects (including COPD, CHF, sleep apnea, history of alcohol and substance abuse, elderly, or history of Renal hepatic dysfunction).
6. Opioids will not combine with sedative-hypnotics, benzodiazepines or barbiturates for chronic non-cancer pain unless there is a specific medical indication for the combination.
7. Assess function and pain status routinely.
8. Monitor for medication misuse and/or drug seeking behaviors (Selling prescription drugs, forging prescriptions, sealing or borrowing drugs, frequently losing prescriptions. Aggressive demand for opioids, injecting oral/topical opioids, unsanctioned use of opioids, unsanctioned dose escalation, concurrent use of illicit drugs, and failing a drug screen).
9. Random urine drug toxicology screening may be done in order to objectively assure compliance.
10. Multi modal forms of pain management are utilized and required by state and federal law as well as all insurance companies.
11. Narcan required for all patients with high dose opioids. Use of other CNS depressants, comorbidities and all pain pump patients.

Complications due to opioid administration explained to the patient.

According to ASIPP commonly known as side effects of opioids include constipation, pruritus, respiratory, depression, nausea, vomiting, delayed gastric emptying, sexual dysfunction, muscle rigidity and myoclonus, sleep disturbance. Morphine has been shown to reduce REM sleep via inhibition of acetylcholine release in reticular activation formation, pyrexia, diminished equivapsychomotor performance, cognitive impairment, dizziness and sedation, all reflecting the effects of opioids at multiple organ systems. An imbalance in the cholinergic/dopaminergic CNS is felt to be the mechanism of opioid induced delirium.

Long term opioid treatment is associated with development of tolerance to its analgesic effects. Many studies have shown that opioid treatment may also paradoxically induce abnormal pain sensitivity, including hyperalgesia and allodynia. Thus, increasing opioid doses may not improve pain control and function.

Reduction or discontinuation of opioids will be considered if function and pain do not improve after a sufficient opioid trial, and/or there is evidence of significant adverse effects from opioid therapy,

Acetaminophen warning with combination products

Hepatotoxicity can result from prolonged use or doses in excess of recommended maximum total daily doses of acetaminophen including over-the-counter products. Short term use (less than 10 days) 4000 mg/day. Long term use 2500 mg/day.

*Reasons to discontinue opioids for refer to addiction management:

- No improvement in function or pain after opioid trial
- Opioid treatment produced significant adverse effects.
- Patient exhibits drug-seeking behaviors or diversion.
- Selling your prescription drugs.
- Forging prescriptions.
- Stealing or borrowing drugs.
- Frequently losing prescriptions.
- Aggressive demand of opioids.
- Injection oral/topical opioids.
- Unsanctioned use of opioids.
- Unsanctioned dose escalation.
- Concurrent use of illicit drugs.
- Failing a drug screen.
- Getting opioids from multiple prescribers.

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Date: _____

Patient Name: _____

Date of Birth: _____

Address: _____

Phone: _____

Recipient: I authorize Indiana Neurology and Pain Center to release my healthcare information to the following recipient(s):

Name: _____

Address: _____

Phone: _____

Fax: _____

Purpose: I authorize the release of my health information for the following specific purpose of:

_____ continuation of care _____ patient request

Information to be disclosed: I authorize the release of the following health information (check the applicable box below)

- All of health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition, communicable diseases, HIV or AIDS and any treatment of alcohol or drug abuse.
- Health records with the exception of the following: _____ Mental or Physical Condition _____ communicable diseases _____ Treatment of alcohol of drug abuse
- Radiology Reports

Term: I understand that this authorization will remain in effect until 1 year of the signed date.

Redisclosure: I understand that my healthcare provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation, or quality of my treatment at INPC. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the INPC Office of Compliance at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my healthcare provider in reliance on this authorization before it is received my written notice of revocation.

Printed Name: _____ Signature: _____

Date: _____

If Individual is unable to sign this authorization, please complete information below:

Name of Representative/: _____ Relationship: _____

Guardian

Date: _____ Witness: _____

PHARMACY DETAIL

NAME: _____

CURRENT PHARMACY: _____

PHARMACY PHONE NUMBER: _____

PHARMACY ADDRESS: _____

OTHER COMMENTS: _____
