TOP PAIN CENTER
TRIUMPH OVER PAIN

1205 Oak Street
North Aurora, IL 60542

Patient Information

Last Name: _____ First: _____

Date of Birth: _____ Social Security #:_____

Street Address: _____

City: _____State: _____ Zip: _____

Email Address: _____

Home phone: _____ Cell Phone: _____

Work phone: _____ Gender: Male _____ Female _____

Patient Race: (circle one): White American Indian/Alaska Native African American Asian Hispanic/Latino

Native Hawaiian/Other Pacific Islander **Preferred Language**: _____

1st Insurance Company: _____ Subscriber/DOB: _____

Effective Date: _____ Relationship to Subscriber: _____

2nd Insurance Company: _____ Subscriber/DOB:_____

Effective Date: _____ Relationship to Subscriber: _____

Primary Care Physician: _____

Referring Physician: (if different) _____

Pharmacy Name: _____**Pharmacy Phone #**_____

Emergency Contact

Name: _____Relationship:_____

Phone: _____

By signing below I acknowledge that I have read and agree to the Financial Policy and Assignment of Insurance Benefits. I have also been offered/given a copy of TOP Pain Center HIPPA Policy and Patient Rights and Responsibilities and I have been given an opportunity to ask questions. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations.

_____ _____ _____

Signature of Patient/Guardian Date

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NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

This is to acknowledge that the patient has received a copy of TOP Pain Center Privacy Policy

The patient understands, acknowledges and agrees that by signing this form: (1) they have received a copy of TOP Interventional Pain Management Center's Joint Notice of Privacy Practices; (2) the physicians exercise their own medical judgment in treating and providing services to patients; (3) the physicians are solely responsible for their compliance with state and federal privacy laws; and (4) nothing in this privacy notice is meant either actual or implied, nor does this privacy notice alter, limit or modify any other consents for treatment or procedures that patients may sign while receiving care at TOP Pain Center.

The patient understands that the Center and physicians use a joint notice and acknowledgment form to comply with federal and state privacy rights and protections for patients. The patient acknowledges and agrees that the use of a joint notice is for convenience of patients.

Patient Name _____

_____

Signature: _____ Date: _____

Relationship to patient: _____

_____

Reason acknowledgment was not obtained: _____

Disposition: File in patient's medical record.

Consent for Treatment and Disclosure Statement

I, _____, acting on behalf of _____
Suffering from conditions requiring treatment, hereby voluntarily consent to such care.

CONSENT: I consent to medical surgical and emergency treatment, radiological and laboratory tests, or other services including nursing care rendered me under general and special instructions of the physicians of the TOP Pain Center (TOP).

- The nature and purpose of the procedure and anesthesia, the benefits to be derived, possible alternative methods of treatment, the risks involved, the possible consequences and the possibility of complications have been explained to me by my physician(s). Also, the relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving treatment have been explained to me. Understanding this, I consent to the recommended operation/procedure.

- I consent to the photographing of procedure(s) to be performed for the purposes of advancing medicine, science and/or education.
- I consent to the presence of a product specialist as deemed necessary by my physician.
- I consent to the performance of operations and procedures in addition to or different from those now contemplated, whether or not arising from presently unforeseen conditions, which the above named doctor or his associates or assistants may consider necessary or advisable in the course of the operation.
- I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained.
- I have been informed that some procedures involve the use of contrast media. Therefore, I have informed my physician of all allergies I have, including any previous reactions to contrast media.
- I understand that my existing DNR order, if any, is rescinded during the period of Surgery and Recovery, unless otherwise requested and documented.
- I understand that some of my treatments will be performed in a hospital or surgery center. These facilities and anesthesia services will bill me separately.

Filing a Complaint: I understand that I or my family have the right to submit a formal complaint to TOP. In order to do so, we must submit the complaint, supporting information and parties relation to the patient to TOP.

Release of Information: I agree that the TOP may release my record and billing information the any insurance company or agencies responsible for paying for the services given to me. I further agree and authorize the TOP to disclose information required by Federal Law for manufacturers to track medical devices in the event such a device is implanted in the course of my treatment. I place no limitations on the release of alcohol, drug abuse, psychiatric record and HIV related results. I further consent to the release of demographic and diagnostic information to the facilities and physicians involving in my treatment.

Medicare Release of Information: I authorize any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf. I have answered the questions regarding my Medicare eligibility to the best of my knowledge.

Valuable and Personal items: I understand that TOP will be responsible for the loss or theft of the personal items and valuables. Any items that are in patient's possession, will be their responsibility to maintain.
I have read and fully understand this form.

_____ _____

Signature of patient or authorized representative Date & Time

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PATIENT INFORMATION

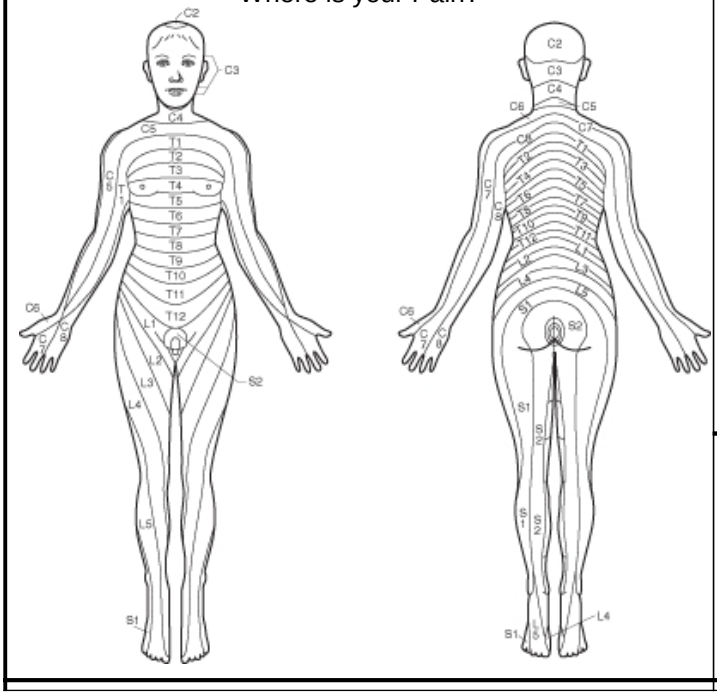
First Name	Last Name	M.I.	Gender M F	Ht ' "	Wt lb	Date of Birth: / /	Marital Status:
Primary Dr.:	Referred by:	Smoking __Years	Alcohol __Years	Drugs __Years		Occupation: _____ Full time Part time Retired None	

History: When:_____	How: __ Spontaneous __ Work __ Injury __ Surgery	Litigations/workman's comp? __ Yes __No	Lawyer/Case manager #

Min Pain (0-10):	Max Pain (0-10):	Current (0-10):	Physical therapy __ , Chiropractic __
Pain Quality (Circle):	Burning Shooting Stabbing Cramping Aching Throbbing Other:		
Aggravated by(circle)	lift Sit Stand Walking Cold Hot Movement (specify):		
Previous treatment	Previous medications		Previous doctor (name & #)
Pharmacy #	Others:		

Current medications (attach list if needed)	Allergies	Previous surgeries **Blood thinners??**

Where is your Pain?



Past Medical Problems: (Check all that apply to you)

__Sinusitis	__ Visual impairment	__ Migraine headaches
__ Hypertension	__ High cholesterol	__ Coronary blockage
__ Arrhythmia	__ Pacemakers	__ Valve disorders
__ Asthma	__ Emphysema/COPD	__ Peptic Ulcers
__ Hepatitis	__ Thyroid disorders	__ Diabetes
__ Stroke	__ Neuropathy	__ MS __Seizures
__ HIV/AIDS	__ **Bleeding prob**	__ Cancers:_____
__ Shingles:_____	__ Kidney disorder	__ Rheumatism
__ Auto immune Dis	__ Vascular Disease	__ Fibromyalgia
__Weight gain	__ Weight loss	__ Chronic fatigue

__ Psychological problem:_____ ___

Others:

Family History:
Mother: _____ Father: _____
Siblings: _____
MRI/CT/X ray:

Signature: _____ Date: _____