HOLISTIC SCIENCE PAIN CLINIC
105 129th Infantry Drive • Joliet, IL 60435
Tel: 815.725.7200 • Fax: 815.725.7258

- We adhere to a zero tolerance policy
  - Please read and sign the narcotic agreement
- All new patients are required to leave a urine specimen
  - You will not be allowed to take the cup and bring urine back to the office
- Patients receiving narcotics are required to submit a urine specimen on a monthly basis
  - Monthly medications will not be refilled prior to 30 days from previous prescription and monthly follow up appointments are required for medication refills.
- Refills will not be issued over the weekend
- Copayments and past due balances are required at the time of visit
- Personal checks are not accepted. We do accept cash, credit and debit cards.
- Patients are required to provide any updates or changes in demographics or insurance.
- If you have union insurance coverage, all procedures must be pre-authorized through the union.
- Cigna patients are responsible for out of pocket costs associated with therapy in office.
- Humana insurance will not cover in office urinalysis screenings- will be patient's responsibility.
- Medicare patients are required to sign an ABN prior to urine toxicity tests in office.
- Weight management patient's: in addition to the fee charged for your medications, we will also bill your insurance company for an office visit or an office visit fee will be charged at time of visit.

Sign:_____ Date:_____

Health and Pain History

Date: _____
Name: _____ DOB _____ Age _____
Referring Physician _____ Primary Care Physician _____
Diagnosis 1. _____ 2. _____

Diagnostic Testing Information (MRI, X-ray, etc.)

Date/Test	Results	Facility where performed

Location of pain: _____
When did your pain start? _____
Pain is described as: ____ burning ____ aching ____ stabbing ____ numbness
____ tingling ____ electric ____ other: _____

Pain level: 1 2 3 4 5 6 7 8 9 10

Pain is: ____ constant ____ intermittent
Pain is increased by: ____ sitting ____ standing ____ walking ____ lifting
____ bending ____ driving ____ arching back ____ lying
____ sneezing ____ coughing ____ other: _____
Pain is decreased by: ____sitting ____ standing ____ walking ____ lying
____ medications ____ other: _____
Pain wakes you up: ____ times per night
What activities make your pain worse? _____
_____
_____

Please note areas of pain on the drawing, using the following symbols to indicate type of pain:

XXXX Stabbing

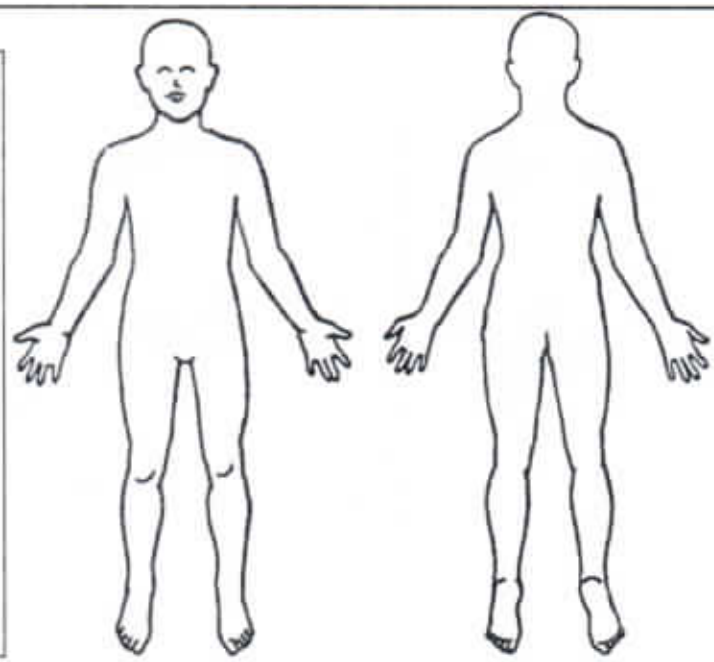
////////// Burning

++++ Numbness

00000 Aching

ZZZZ Shooting

****** Electric



Health History – Page 2

Height ____ Weight ____ R/L Handed ____

Current Medications (include ASA, NSAIDS, Blood Thinners)

Medication Name	Dosage	Quantity

Please List Any Allergies to Medications or Shellfish

Medication Name	Allergic Reactions

Please check any of the following conditions which you have now or have had in the past:

____ Asthma or Lung Problems
____ Heart Problems
____ Stroke
____ High Blood Pressure
____ Blood Clots
____ Bleeding Tendency
____ Bruise Easily
____ Cancer
____ Diabetes
____ Other
____ Depression
____ Kidney or Liver Problems
____ Hepatitis
____ Seizures
____ Thyroid Problems
____ Sickle Cell Disease
____ Glaucoma
____ HIV Positive
____ Stomach Ulcers / Hiatial Hernia

If yes, please explain briefly: _____

_____

Previous Surgeries: _____

_____

Social History: Do you smoke? If yes, how much? _____

Do you drink alcohol? If yes, how much? _____

History of drug abuse? If yes, please explain: _____

_____

Occupation: _____ Marital Status: _____

Are you currently involved in litigation? If yes, please explain: _____

_____

Family History: Heart Disease Diabetes Depression Cancer Arthritis

Lung Disease Other: _____

Registration Form

Name: _____ Date of Birth: ___/___/___ Sex: M ___ F___
Address: _____ City: _____ State: ___ Zip: _____
Home #: _____ Wk #: _____ Cell #: _____
SS#: _____ Marital Status: _____
Email: _____

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____
Address: _____ City: _____ State: ___ Zip: _____
Phone #: _____

PARENT/GUARDIAN INFORMATION

Name: _____ Date of Birth: ___/___/___ Relation to Pt: _____
Address: _____ City: _____ State: ___ Zip: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID #: _____ Grp #: _____
Address: _____ City: _____ State: ___ Zip: _____
Phone #: _____ Eff Date: _____
Policyholder's Name: _____ Policyholder's Date of Birth: ___/___/___

Secondary Insurance: _____ ID #: _____ Grp #: _____
Address: _____ City: _____ State: ___ Zip: _____
Phone #: _____ Eff Date: _____
Policyholder's Name: _____ Policyholder's Date of Birth: ___/___/___

AUTO/WORKMAN'S COMP INFORMATION

Date of Accident: ___/___/___ Insurance Co Name: _____
Address: _____ City: _____ State: ___ Zip: _____
Claim #: _____ Contact Person: _____ Tel #: _____

EMERGENCY CONTACT

Name: _____ Relation to Patient: _____
Home #: _____ Wk #: _____ Cell #: _____

I hereby authorize Dr. Asad Cheema, M.D. to release to my insurance company any information acquired in the course of my examination or treatment which is necessary to process claims for services rendered. I hereby authorize and direct my insurance carrier to pay directly to Dr. Cheema any benefits due me under my insurance plan. I certify that the information above is correct and I understand that any remaining unpaid balance after contractual discounts are taken into consideration will be my responsibility.

Signature: _____ Date: _____

Dr. Asad Cheema, M.D. – Board Certified Anesthesiologist and Interventional Pain Specialist
Phone: 815-725-7200 Fax: 815-725-7258

AUTHORIZATION FOR RELEASE OF INFORMATION/MEDICAL RECORDS

I AUTHORIZE DR. ASAD CHEEMA TO RELEASE TO MY INSURANCE CARRIER OR OTHER CATEGORY OF THIRD PARTY PAYOR, MEDICAL REVIEW PROGRAMS/AGENCIES CONTRACTING WITH THIRD PARTY PAYOR, THE SOCIAL SECURITY ADMINISTRATION UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT, OR OTHER INTERMEDIARIES RESPONSIBLE FOR PAYMENT OF MY MEDICAL CHARGES THE FOLLOWING INFORMATION: DIAGNOSIS AND OTHER MEDICAL INFORMATION FOR THE PURPOSE OF SECURING PAYMENT OF MY MEDICAL TREATMENT. I UNDERSTAND THAT I CAN REVOKE THIS CONSENT AT ANY TIME BY GIVING WRITTEN NOTICE TO DR. ASAD CHEEMA. I UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT AND COPY THE INFORMATION TO BE DISCLOSED. I UNDERSTAND THAT IF I REFUSE TO CONSENT TO THIS RELEASE OF INFORMATION, I WILL BE HELD PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL MEDICAL CHARGES RELATED TO THIS TREATMENT. I HEREBY REPRESENT AND WARRANT TO DR. ASAD CHEEMA THAT I HAVE COMPILED WITH ALL OF THE REQUIREMENTS OF MY MEDICAL INSURANCE CARRIER, OR THE HEALTHCARE SERVICE PROVIDER, PRIOR TO HAVING THE PROCEDURE SET FORTH AT PARAGRAPH 1, INCLUDING OPTAINING ANY PRECERTIFICATION OR PERMISSION NECESSARY. IN THE EVENT I HAVE NOT SO COMPILED, I EXPRESSLY AGREE TO PAY DR. ASAD CHEEMA ALL CHARGES, FEES AND COSTS NOT PAID BY MY INSURER OR OTHER HEALTHCARE SERVICE PROVIDERS.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I AUTHORIZE PAYMENT OF ALL MEDICAL BENEFITS TO WHICH I AM OR MAY BE ENTITLED TO BY A PRIVATE OR PUBLIC PAYOR DIRECTLY TO DR. ASAD CHEEMA, M.D. I UNDERSTAND THAT I WILL BE FULLY RESPONSIBLE FOR PAYMENT OF ANY AND ALL CHARGES NOT COVERED BY MEDICAL INSURANCE.

CANCELLATION/NO SHOW POLICY

PLEASE BE ADVISED THAT WHEN YOU SCHEDULE AN APPOINTMENT WITH OUR OFFICES YOU ARE MAKING A RESERVATION WITH A LICENSED PROFESSIONAL. THEREFORE SAME DAY CANCELLATIONS AND NO SHOWS WILL BE SUBJECT TO A $100.00 FEE PER INCIDENT.

FEES NOT COVERED BY INSURANCE

I HAVE READ, REVIEWED AND AGREE TO THE HANDOUT AND INFORMATION PROVIDED CONCERNING ADMINISTRATIVE FEES OR PATIENT SERVICES NOT COVERED BY INSURANCE.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN GIVEN AN OPPORTUNITY TO REVIEW IT.

I HAVE READ AND REVIEWED THE ABOVE INFORMATION:

PATIENT NAME (PRINT): _____ DATE OF BIRTH: ____/____/____

PATIENT, PARENT OR LEGAL GUARDIAN
SIGNATURE: _____ DATE: _____

WITNESS TO SIGNATURE: _____

Pain Medication Policy Agreement

Before any medications are prescribed for your pain, you will need to be aware and familiar with the Pain Medication Policy pertaining to use and risk of these medications, and agree to fully adhere to the Policy at all times.

Please carefully read each item of the Policy. Check the box next to each item to indicate that you have read, understood and verify the information.

☐ **Initial patient evaluation** No controlled substances will be prescribed on your first visit to the office. By law and by the State's Board of Medical Examiners, we are required to gather a comprehensive medication history before beginning the prescription of these substances. It is also our policy not to write prescriptions for controlled substances, before the Narcotic contract is signed. The law requires that there be a patient-physician relationship established before treatment is undertaken. Prescriptions will not be written for any non-patients.

☐ **Controlled substance agreement** This Agreement must be read and signed before any prescription medications are to be dispensed. It contains important information pertinent to the use of these substances.

☐ **Telephone calls** No prescriptions will be "refilled" or "called-in or faxed" to your pharmacy over the phone In addition, no medication changes will be made over the telephone. This policy applies to refilling prescriptions and any new medications.

☐ **After business hours, holidays, and weekends** No prescriptions will be written at these times. Prescriptions will be written only during regular business office hours. Therefore, it is your responsibility to closely monitor your supply of medications.

☐ **Appointments** Offices Business hours are Monday thru Friday 8:30 AM to 5 PM.

☐ **Drug screening tests and follow-up** By law and by the State's Board of Medical Examiners, requires documentation of your use of controlled substances. Therefore, you will be required to provide urine and/or blood samples for the purpose of random drug screening tests. It is unethical and illegal to prescribe medications without adequate medical follow-up. Therefore, not keeping your regular appointments constitutes a violation of the follow-up policy, jeopardizing the continuation of your medication(s).

☐ **Sharing medications** is strictly prohibited. Medications are only to be used by you as prescribed.

☐ **State and Federal laws strictly prohibit selling or distributing** This is an illegal practice and could result in criminal drug charges.

☐ **Lost or stolen medications or prescriptions** will not be replaced under any circumstances and "police reports" will not justify replacement of medications.

☐ **Obtaining pain medications from more than one physician** is called "doctor shopping" and State Law strictly prohibits it. This is an illegal practice and could result in criminal drug charges.

☐ **Obtaining pain medications from any other sources** is strictly prohibited. You are not to obtain any pain medications from friends, family members, street drug dealers, or Internet pharmacies.

☐ **Picking-up prescriptions without an appointment** is not permitted by you or your designee. You must attend office appointments in order to be assessed for the need to continue taking the mediation(s). Prescriptions will only be given only to whom they were intended, and only during regular office visits.

☐ **Identification** You are required to have a current, valid Photo I.D. on file in the office, and you may be asked for identification before receiving your prescription for a controlled substance or other medications.

☐ **Driving or operating heavy machinery** is prohibited when taking controlled substances. In certain cases an evaluation may be required to determine if you are able to safely operate a vehicle.

☐ **Handling firearms or other weapons** is strictly prohibited when taking controlled substances.

☐ **Pregnancy or lactation** Taking controlled substances while pregnant may cause fetal abnormalities as well as fetal addiction and perinatal withdrawal syndrome. I am not pregnant and will notify Dr. Cheema immediately if I become pregnant.

☐ **Use of alcohol** is strictly prohibited when taking controlled substances. Combining alcohol and pain medications may result in serious illness or death.

☐ **Illegal drug use** is strictly prohibited and you will be discharged from the pain program for use of illegal drugs or abuse of medications. I certify that I am not in treatment for substance dependence or abuse, and that I am not currently using any illicit drugs including marijuana, cocaine, etc.

☐ **Using suicide as a threat** will result in immediate discontinuation of all pain medications and mandatory, possibly involuntary, institutionalization in an inpatient psychiatric facility.

☐ **Suicidal attempts** will result in immediate and complete discontinuation of all medications with the potential for self-harm. Furthermore, your clinical care will be transferred to a psychiatric program. Go immediately to a hospital ER if you feel suicidal.

☐ **Unused portion of prescription** medications should be taken to all of the Pain Clinic's appointments for the purpose of drug counts. Discontinued medications should also be taken to your appointments for the purpose of being discarded with adequate documentation and in front of witnesses. A sample may be sent out for analysis and identification. We will not accept video recordings as proof of disposal.

☐ **Medication prescriptions** will be issued only in the office, during regular business hours. No prescriptions will be called in, faxed, or mailed to your pharmacy. This is necessary for maintaining strict control and documentation on the distribution of these controlled substances.

☐ **Mail-in Prescription services and medication assistance programs** We are not responsible for handling of your prescriptions or your medications via a third party. When using either one of these medication services, be advised that we are not responsible for problems that you may experience when using them. If your prescriptions or medications are lost in the mail, or there is any delay in the shipments, we will not issue additional prescriptions "to keep you until the medicines arrive." Also, we will not be "calling the third party for you," to speed up the process, or to see what is happening. In addition, there are "Mail-in Prescription Services" that require that a prescription for 90 day supply be written, instead of one with refills. We believe this to be inappropriate and unsafe, when dealing with controlled substances. Because of this, we will not be writing for such prescriptions. In general, we do not believe that "Mail-in Prescription Service Programs" are appropriate for "Controlled Substances." If a medication is lost in the mail, we do not replace it. We do not accept "U.S. Postal Service Mail loss/rifling report" as proof of loss.

☐ **I authorize Dr. Asad Cheema, M.D.** and my pharmacy to cooperate fully with any investigation by city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the possible misuse, sale, or other diversion of my pain medication. I authorize Dr. Cheema to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

☐ **Sharing and obtaining information** I agree to allow Dr. Cheema to share and/or obtain medication related information with/from my other treating physicians. This is essential if adverse medication interactions are to be avoided. I agree to allow Dr. Cheema to freely discus my case with any other physician currently or previously involved in my medical care.

☐ **Character and intensity of pain** I will communicate fully with Dr. Cheema about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication(s) are helping to relieve my pain.

☐ **Pain treatment goals** I understand that Dr. Cheema will discuss the use of narcotic medications with me, including the issues of appropriate realistic goals, side effects and specific issues of developing tolerance dependence, habitation, addiction and withdrawal problems due to these medications and that I will have a chance to ask questions regarding the use of narcotic/opioid medications.

☐ **Psychotropic medications will not be prescribed** I understand the benzodiazepines medications such as Valium (diazepam), Xanax (Alprazolam), or Ativan (Lorazepam) will not be prescribed. If you are currently taking these medications, they must continue to be prescribed by your physician that initiated the psychotropic medication therapy, or a licensed psychiatrist.

☐ **Periodic Clinical Review** I understand that the benefit of the narcotic/opioid pain medication will be evaluated periodically using the following criteria; degree of pain relief, increase in general functioning; increase in exercise activities, behavioral adjustment, completion of rehabilitation program; return to work status; and maintenance or return to employment.

☐ **Disruptive or unacceptable behavior** Patterns may result in discontinuing your narcotic/opioid medications.

☐ **Follow-up appointments** I understand that I must keep office appointments as recommended by Dr. Cheema and that failure to comply may cause discontinuation of my narcotic/opioid prescriptions.

☐ **Multiple pharmacies** are not permitted. You must agree to use a single pharmacy to obtain your pain medication. This pharmacy will be of your own choosing. You are responsible for providing the name, location and telephone number of your pharmacy. If for whatever reason you decide to change your pharmacy, you must immediately provide the name, location and telephone number of the new pharmacy.

I agree to use **only** the following pharmacy:

Name of Your Pharmacy:

_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____

Pain Medication Policy Agreement

I am in full agreement with the terms of the Pain Medication Policy. I have read and understand all of the information in the Pain Medication Policy and all of my questions and concerns regarding treatment have been adequately answered.

I understand that the purpose of this Agreement is to prevent misunderstandings about certain medications I will be taking for pain management. This is to achieve compliance with the laws related to the prescribed use of controlled pharmaceuticals.

I understand that if I break any term of this Agreement, Dr. Cheema may stop prescribing these pain control medications and has the right to discharge me from his care. In this case, he shall provide me with a thirty (30) day period, and Dr. Cheema shall provide me with contact telephone numbers to assist in my selection of a new physician.

I understand that this Agreement is essential to the trust and confidence necessary in the physician-patient relationship and that Dr. Cheema undertakes to treat me based on this Agreement.

I have received a copy of this document for my records.

This Agreement of the Pain Medication Policy is entered into on this _____ day of _____.

Patient Signature: _____

Printed Patient Name: _____

Physician Signature: _____

Witnessed By: _____

Printed Witness Name: _____