Midwest NEUROSCIENCE INSTITUTE
Research Medical Center

Patient History

Name_____ Birth Date: _____ Age_____ Sex _____

What Dr. requested that you see our physicians? _____ Phone _____

Family Physician or Internist: _____ Phone _____

What is your major problem or complaint? _____

When did your problem start? _____ Was there a specific injury? _____ Date of Injury_____

DO YOU CONSIDER THIS WORK OR AUTO RELATED INJURY? _____ Why?_____

Have you seen other doctors for this problem? _____ Who? _____

Past Medical History

□ MEDICAL HISTORY NEGATIVE

Cardiovascular (heart):
□ Atrial fibrillation / arrhythmia
□ Congestive heart failure
□ Coronary Artery Disease
□ Deep Vessel Thrombosis (DVT/ blood clot)
□ Hypertension (high blood pressure)
□ Peripheral Vascular Disease

Respiratory:
□ Asthma
□ Seasonal Allergies
□ Sleep Apnea / CPAP
□ COPD

Gastrointestinal:
□ GERD (reflux)
□ Colon/ Rectal: _____
□ Irritable Bowel Syndrome
□ Peptic ulcer
□ Liver disease
□ Hepatitis

Metabolic:
□ Diabetes: Type I / Type II
□ Hyperlipidemia (high cholesterol)
□ Thyroid dysfunction
□ Obesity

Musculoskeletal:
□ Fibromyalgia
□ Gout
□ Osteoarthritis
□ Osteoporosis
□ Rheumatoid arthritis

Cancer:
Indicate type, treatment, year
□ Breast: Right/ Left
□ Colon
□ Lung
□ Prostate
□ Other: _____

Neurologic / Psychiatric:
□ Anxiety disorder
□ Bi-polar disorder
□ Depression
□ Dementia
□ Migraine headaches
□ Multiple Sclerosis
□ Peripheral neuropathy
□ Parkinson's disease
□ Seizures: last seizure_____
□ Stroke

Infectious:
□ Shingles
□ Methicillin resistant staph aureus (MRSA)
□ HIV / AIDS

Other:
□ Chronic Kidney disease
□ Glaucoma
□ Other: _____

Past Surgical History: *INCLUDE DATE(S)*

□ NO PRIOR SURGERIES
□ Tonsillectomy _____
□ Appendectomy (appendix) _____
□ Cholecystectomy (gallbladder) _____
□ Vasectomy _____
□ Tubal Ligation _____
□ C-Section _____
□ D&C _____
□ Hysterectomy_____

□ Other:_____

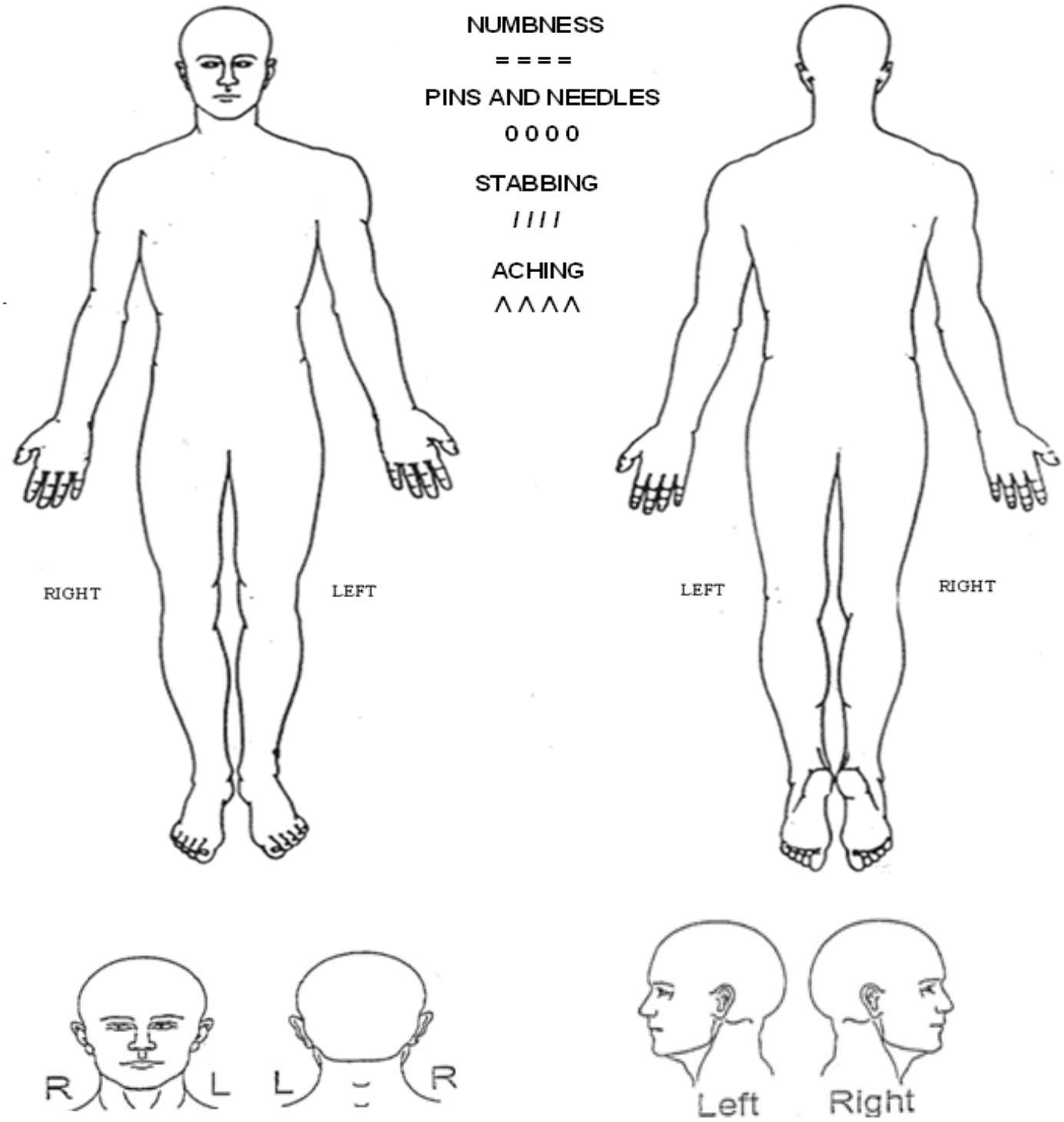
□ Other:_____

□ Other:_____

Do you have metal in your body? Yes / No
If yes, is it MRI compatible (titanium)? Yes / No

Patient Name Date of Birth _____

Mark these drawings according to where you hurt (if the back of your neck hurts, mark the drawing on the back of the neck, etc.) If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram.



Please describe in detail the type of pain you are having and the exact location.

_____

_____

NAME:_____ **DOB:**_____

Medications: □ Not Currently Taking Any Medications

Include prescription, over-the-counter drugs, vitamins, herbals, etc.

Preferred Pharmacy:

Name:_____ Address: _____ City, State:_____ Phone:_____

Medication Name	Dose / Amount / Frequency	Reason for Taking	Prescribing Doctor

□ Please attach additional page, if more space is needed for complete medication list.

Do you currently have a pain medication contract with another physician? If yes, whom? _____

Drug Allergies and Reactions: □ No Known Drug Allergies

Medication Name	True Allergy (facial swelling, airway tightening, hives)	Adverse Reaction (nausea, vomiting, upset stomach, headache)	Date

Allergy to: □ Latex □ Betadine □ Shellfish □ IV Contrast / Dye □ Other: __

NAME:_____

Family Medical History:

Diseases in your family: □ Heart Disease □ Hypertension (high blood pressure)
□ Diabetes □ Cancer (type):_____
□ Hereditary Disorders:_____
□ Other:_____
□ Adopted / Family history not available. □ Family history negative.

Social History:

Marital Status:
□ Currently married □ Divorced
□ Single □ Widowed

Number Of Children:

Occupation:_____

Military History:_____

Alcohol Use: □ No alcohol
□ Consume: Beer / wine / hard liquor
Amount / frequency: _____
□ Social drinker
□ Drink in moderation (2 drinks day)
□ Drink in excess (more than 2 drinks per day)

Tobacco History: □ Never a smoker
□ Former smoker: Date quit_____
□ Current smoker: Packs per day_____
Number of years_____
□ Chewing tobacco

Illicit or IV Drug Use: □ Never used
□ Currently using illicit drugs
□ History of illicit drugs
□ Type/Frequency:_____
□ Previously treated for substance abuse

Review Of Systems (check all present): ALL OTHER SYSTEMS NEGATIVE

Constitutional:
□ Chills
□ Fatigue
□ Fever
□ Weight Gain _____lbs
□ Weight Loss _____lbs

Eye:
□ Blurry Vision
□ Double Vision

Ear Nose Throat:
□ Earache
□ Hoarseness
□ Loss of Hearing
□ Nasal Congestion
□ Ringing in Ears
□ Sinus Pain

Cardiovascular:
□ Chest Pain
□ Edema (leg swelling)
□ Palpitations (irregular heart beat)

Endocrine:
□ Excessive Thirst
□ Decreased Libido

Respiratory:
□ Cough
□ Coughing up Sputum
□ Short of Breath
□ Wheezing
□ Home oxygen use (___L)

Gastric:
□ Abdominal pain
□ Constipation
□ Decreased appetite
□ Diarrhea
□ Difficulty swallowing
□ Heartburn
□ Nausea
□ Vomiting

Genital / Urinary:
□ Dysuria (Pain on urination)
□ Hematuria (Blood in urine)
□ Nocturia (more then 2 urinations during night)
□ Urinary frequency
□ Urinary incontinence
□ Urinary hesitancy
□ Painful intercourse

Musculoskeletal:
□ Joint pain
□ Muscle aches
□ Muscle weakness

Neuro:
□ Headache □ Dizziness
□ Memory Loss
□ Syncope
□ Numbness / Tingling
□ Claustrophobia

Integument:
□ Skin Rash

Psych:
□ Anxiety
□ Depression
□ Sleep disturbances

Hematologic /Lymph:
□ Anemia
□ Excessive bleeding during surgery

Immune System:
□ Impaired immunity

□ REVIEW OF SYSTEMS NEGATIVE

Preventative Care

Did you receive the ***Flu Vaccine*** during flu season (between Sept – Feb)? Yes / No

Have you ever received the ***Pneumonia Vaccine***? Yes / No

Height:	Weight: lbs

For office use:	BP= /	P=	T=

2330 East Meyer Blvd
Kansas City, MO 64132
Phone: 816-363-2500

Pain Disability Index Sheet

Patient Name: _____ Date: _____

Pain disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that described the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally have been involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Occupational: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing

No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Patient Name _____ DOB: _____

Short-Form McGill Pain Questionnaire-2 (SF-MPQ-2)

This questionnaire provides you with a list of words that describe some of the different qualities of pain and related symptoms. Please put an **X** through the numbers that best describe the intensity of each of the pain and related symptoms you felt during the past week. Use **0** if the word does not describe your pain or related symptoms.

1.	Throbbing pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
2.	Shooting pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
3.	Stabbing pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
4.	Sharp pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
5.	Cramping pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
6.	Gnawing pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
7.	Hot-burning pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
8.	Aching pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
9.	Heavy pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
10.	Tender	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
11.	Splitting pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
12.	Tiring-exhausting	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
13.	Sickening	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
14.	Fearful	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
15.	Punishing-cruel	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
16.	Electric-shock pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
17.	Cold-freezing pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
18.	Piercing pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
19.	Pain caused by light touch	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
20.	Itching	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
21	Tingling or “pins and needles”	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
22	Numbness	none	0	1	2	3	4	5	6	7	8	9	10	worst possible

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PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Full Name (if different from above): _____ Date Of Birth: _____

Address: _____City, State, Zip :_____

Primary Care Physician: _____ Address/Phone: _____

Referring Physician _____Address/Phone: _____

Home #:_____Cell:_____ Work #: _____

Employer: _____ FT____ PT____ Self____ Retired____ Not Employed ____

E-Mail Address: _____ Patient Social Security Number _____

Gender: ☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Hispanic ☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc
☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian
☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last)_____(First)_____(MI) _____

Date of birth: MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male

Responsible Party Social Security Number:_____-_____-_____ Phone number: _____

Address:_____ City: _____, State:_____ Zip _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

Auto related? ☐ Yes ☐ No Work Related? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____

Phone number:_____ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient:_____ ☐ Guardian

Address_____

City, State, Zip: _____

Home phone:_____Work hone:_____Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. ***This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).***

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any satellite office under common ownership. This consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions***. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.*** I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its consent.

Signature of patient or personal representative: _____ Date: _____

Printed Name of patient or personal representative: _____ Date: _____

Patient Name (Printed): _____ **Date of Birth:** _____

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Notice of Privacy Practice/clinics.

_____ (Patient/Representative initials) I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice/clinics.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent ____ (Patient/Representative Initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

-OR-

I do not consent ____ (Patient/Representative Initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities).

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:

We want to stay connected with our patients. Patients in our practice/clinic may be contacted via email, calls to your cellular telephone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device), and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email, cellular telephone number, address or text number below, you understand that you may get these communications from the Practice/clinic. You may opt out of these communications at any time (see next page).The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I authorize to receive text messages and/or cellular telephone calls for appointment reminders, feedback, and general health reminders/information and **the cell phone number is** _____.

I authorize to receive email messages for appointment reminders and general health reminders/feedback/information and **the email that i**s_____.

-OR-

I **decline** _____ (Patient/ Representative Initials) to receive communication via text.

I **decline** _____ (Patient/ Representative Initials) to receive communication via cellular telephone call.

I **decline** _____ (Patient/ Representative Initials) to receive communication via email.

Note: *This clinic uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.*

Patient Name (Printed): _____ **Date of Birth:** _____

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ____ ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:
  - Name: _____ Date: _____
  - Name: _____ Date: _____
- ____ ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature _____ **Date:** _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ **Date of Birth:** _____

Only If you have previously consented to receive communication via text/cellular telephone call/email and wish to remove the consent/Opt Out/Revocation of communications via email and/or text or cellular telephone call. In other words, I do not want my email address or cell number to be used any longer for the above mentioned communications.

*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **text**.*
*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **cellular telephone call**.*
*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **email**.*

Patient Name: _____

Patient/Patient Representative Signature: _____
Date: _____ *Time:* _____

Patient Name (Printed): _____ **Date of Birth:** _____

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

Financial Agreement

- I acknowledge, that as a courtesy, Research Neuroscience Institute, LLC may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge Research Neuroscience Institute, LLC may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to Research Neuroscience Institute, LLC any insurance or other third-party benefits available for health care services provided to me. I understand Research Neuroscience Institute, LLC has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Research Neuroscience Institute, LLC I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Research Neuroscience Institute, LLC by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for Research Neuroscience Institute, LLC or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Research Neuroscience Institute, LLC or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Research Neuroscience Institute, LLC or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ **Date:** _____

If you are not the patient, please identify your relationship to the patient below:

☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Guarantor ☐ Healthcare Power of Attorney ☐ Other/Please Specify _____

PATIENT CONSENT FOR ePrescribe PROGRAM

ePrescribing is a way for doctors to send an accurate, error free, and understandable electronic prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.

- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

By signing this consent form, you are agreeing that your provider may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Research Neuroscience Institute, LLC to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient/patient representative signature: _____ **Date:** _____

Center For The Relief of Pain

Missed Appointment Policy

At the Center for the Relief of pain, your time is valued. Our physicians strive to see patients in a timely manner. We respect your time and ask you to respect our time and other patients' needs by keeping your appointment. Each appointment time slot is important and cannot be recovered if a patient chooses not to keep their appointment. We collect fees to ensure that our physicians can continue to see patients. Please keep in mind that each skipped or missed appointment is not just time lost, but also time when other patients cannot be seen.

Please refer to the guidelines below to learn more about our Missed Appointment policy:

- It is your responsibility to provide us with a working telephone number to allow us to communicate important information, such as laboratory results, and provide telephone reminders of scheduled appointments. Having a valid telephone number is truly important: please help us to maintain your records.

- Effective September 1, 2011, each missed appointment will be flagged and you will receive a notice that you have missed your appointment. In addition, your account will be assessed a $25 missed appointment fee. Please note that the fee will not be billed to your insurance.

- Accounts that accumulate three missed appointment fees may be dismissed from the practice.

- Any cancellation not made at least 24 hours before the scheduled appointment is considered a missed appointment and subject to the terms above.

- If you arrive 20 minutes late for your scheduled appointment, without prior notification to our office, this may also be considered a "missed appointment" and, at very least may cause us to reschedule your appointment. Please remember that communicating with our office is critical to us providing you with quality health care.

- We understand that circumstances occur that do not allow you to keep your scheduled appointment. If this is the case, please call and discuss this with the office staff as soon as possible. We will waive the cancellation fee for this appointment as long as you do hot have a history of cancellations. Our schedule fills up quickly, and this will allow other patients to fill those slots.

We realize that there are times that you may arrive for a scheduled appointment time and are not able to be seen promptly at your appointed time. Please know that we go out of our way to make certain that this does not happen, however due to patient emergencies or other unexpected incidents, our schedule may occasionally fall behind. If this is the case, we will make every attempt to let you know that status of our schedule.

Name of Patient: _____

Signature of Patient: _____ Date: _____