MIPM
Minnesota Institute for Pain Management

2780 Snelling Ave. N., Suite 304, Roseville, MN 55113
12400 Portland Ave South Suite # 110 Burnsville, MN 55337
Ph: 651-433-7255 Text Line: 651-815-8155 Fax: 651-888-2611

Minnesota Institute of Pain Management, LLC
PATIENT INFORMATION SHEET

Date:_____

Patient Name _____ Date of Birth _____

Address _____City_____

State_____ Zip_____ Email Address: _____

Home Phone_____ Work Phone _____ Cell Phone_____

Date of Injury _____

Employer_____

Sex: _____ Marital Status: _____

Insurance information:

Type of insurance:_____ (auto, medicare, work comp, other)

Primary Ins Company:_____ ID/Policy/Claim # _____ Group# _____

Adjuster: _____Ins Co. Ph_____

Effective Date of Coverage: _____

Send claims to: _____ City_____ St _____Zip_____
Fax number: _____

Name of Insured (Owner of Policy) _____Insured's DOB:_____
Insurance Benefit Verification: (please take a copy of front and back of insurance card)

Secondary Ins Company _____ ID/Policy/Claim # _____ Group# _____

Attorney Information:

Name of Attorney_____ Phone number _____

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Patient Name: _____

Consent for Treatment

I, the undersigned patient, or parent or guardian of the patient, authorize Minnesota Institute for Pain Management, LLC to perform medical evaluation and treatment as is appropriate to the patient's condition. I understand that no guarantee has been made as to the results of treatment.

_____ _____
(Patient Signature) (Date)

_____ _____
(Parent or Guardian Signature) (Date)

I verify by my signature that I have reviewed the written privacy practices of Minnesota Institute for Pain Management, LLC and have received a copy of these, or have declined a copy of these, or have been offered the opportunity to review these and have declined to review them. In any of these instances, I agree to these practices.

_____ _____
(Patient Signature) (Date)

_____ _____
(Parent or Guardian Signature) (Date)

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DATE:_____

Patient Name: _____ Date of Birth: _____

Patient Address:

_____

Patient Phone Number:_____

Email Address: _____

Claim # _____

I HEREBY AUTHORIZE SERVICES RENDERED TO ME BY MINNESOTA INSTITUTE FOR PAIN MANAGEMENT AND AGREE TO PAY FOR SUCH SERVICES INCLUDING THOSE SERVICES CONSIDERED NON-COVERED OR DENIED BY MY INSURANCE COMPANY, **I ALSO AUTHORIZE THOSE ITEMS CHECKED BELOW.**

☐ I hereby authorize that payment of the amount due me in my pending insurance claim be made directly to Minnesota Instut e for Pain Management. Payment is authorized upon your receipt of an itemized statement of services.

☐ **PRESCRIPTION HISTORY RELEASE**
I hereby authorize Minnesota Instut e for Pain Management to view my prescripon history when providing evaluaon or treatment services to me.

☐ **RECORDS RELEASE**
I hereby authorize the exchange/release of any informaon via paper or electronic review, by Minnesota Instut e for Pain Management with any providers, hospitals, and/or specialists to whom I may receive care from or be referred to, or to my insurance company to determine benefits and secure payment for services provided. In addion, I authorize Minnesota Instut e for Pain Management to exchange/release any informaon via paper or electronic review to any a orney represenng me for a motor vehicle accident or workman's compensaon claim for services rendered by Minnesota Instut e for Pain Management. Minnesota law requires us to inform you that your medical records, no ma er when created, may be released for the p**PATIENT AUTHORIZATION FORM**urpose of medical or scienfic research unless a wri en objecon is received.

☐ **HEALTH DATA EXCHANGE**
I authorize my insurer, health plan, or claims administrator and provider to share with each other my health information on for care coordination on and quality improvement purposes. This includes sharing my health information from treatment I have received at health care providers not related to Minnesota Institute for Pain Management. My insurer, health plan, or claims administrator may also share the above information with a care system or accountable care organization in which Minnesota Institute for Pain Management participates. If I do not want my health information shared for these purposes, I may opt out by checking the statement below.

☐ I do not authorize my insurer, health plan, or claim administrator and provider to share my health informa on as directed above.

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I HAVE RECEIVED THE MATERIAL ON EACH LINE CHECKED BELOW:

☐ NOTICE OF PRIVACY PRACTICES (UNLESS RECEIVED DURING A PREVIOUS VISIT)

☐ CREDIT POLICY (UNLESS RECEIVED DURING A PREVIOUS VISIT)

☐ MEDICARE PATIENT SIGNATURE AUTHORIZATION

I authorize any holder of medical or other information about me to be released to the Center for Medicare/Medicaid Services, or its intermediaries or carriers, or billing agent of this physician or supplier any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and I request that payment under Medicare be made either to me or Minnesota Institute for Pain Management on any bills for services furnished me by that physician/clinic.

Signature_____

Date_____

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ASSIGNMENT OF INSURANCE BENEFITS FORM

PATIENT NAME:_____

DATE OF ACCIDENT: _____

Insurance Company:

1. I understand that Minnesota Institute for Pain Management, LLC requires payment at the time of treatment and that the clinic is waiving the right to payment at the time of treatment because I am signing this assignment.
2. I fully understand that I am directly and fully responsible to Minnesota Institute for Pain Management, LLC for all medical bills submitted by the doctor for services rendered me unless they are under a health plan with which Minnesota Institute for Pain Management, LLC has a signed contract. I understand that Minnesota Institute for Pain Management, LLC does not have a signed contract with any automobile accident or personal injury insurance companies.
3. In consideration for Minnesota Institute for Pain Management, LLC awaiting payment, I further understand that such payment is not contingent on any settlement of insurance benefits by which I may eventually recover this doctor's fee.
4. I hereby authorize Minnesota Institute for Pain Management, LLC to furnish the insurer with a complete invoice for any services rendered in regard to the accident in which I was personally involved.
5. 1 hereby authorize and direct the insurer to withhold and pay directly to Minnesota Institute for Pain Management, LLC such sums as may be due and owing to my doctor for medical services rendered to me both by reason of this accident and by reason of any other bills that are due their office from any settlement or payment as may be necessary to adequately protect and compensate Minnesota Institute for Pain Management, LLC
6. I agree that the amount to be paid to Minnesota Institute for Pain Management, LLC will not be lessened in any amount due to a deductible or a settlement for less than 100% of the total amount of damages.
7. I hereby agree to assign any claim, insurance benefits, or settlement amount arising out of or in any way connected with this accident in the full amount which is due and owing to Minnesota Institute for Pain Management, LLC

DATE:_____

SIGNATURE_____

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LETTER OF PROTECTION AND DOCTOR'S LIEN

Patient Name:_____ Date of Accident:_____

1. I understand that Minnesota Institute for Pain Management, LLC requires payment at the time of treatment and that the clinic is waiving its right to payment at the time of treatment in consideration for this assignment.
2. I fully understand that I am directly and fully responsible to Minnesota Institute for Pain Management, LLC for all medical bills in reference to the above date of injury which are submitted by the doctor for services rendered me and that this Assignment is solely for the doctor's additional protection and in consideration for his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover this doctor's fee. I understand that Minnesota Institute for Pain Management, LLC services are overdue if not paid within 30 days. I understand and agree that Minnesota Institute for Pain Management, LLC will charge 8% interest for all overdue services, as well as any costs of collections, including reasonable attorney fees and any costs arising out of any lawsuit. I understand and agree to assign to Minnesota Institute for Pain Management, LLC my right to the 8% interest per annum for their medical services that are not paid within 30 days pursuant Minn. Stat. §65B.54, subd. 2.
3. I hereby authorize Minnesota Institute for Pain Management, LLC to furnish my attorney with a full report of my doctor's examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was personally involved.
4. I hereby authorize and direct my attorney to pay directly to Minnesota Institute for Pain Management, LLC such sums as may be due and owing to my doctor for medical services rendered to me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and compensate Minnesota Institute for Pain Management, LLC
5. I further give a lien on my case to Minnesota Institute for Pain Management, LLC against any and all proceeds of any settlement, judgment, or verdict, which may be paid to my attorney or myself, as a result of the injuries for which I have been treated, or injuries in connection therewith. I agree that neither this agreement nor the lien created thereby can be cancelled without prior notice and payment to Minnesota Institute for Pain Management, LLC
6. I further acknowledge that in settling lawsuits, frequently interested parties will settle for less than 100% of the total amount of damages. However, I understand that Minnesota Institute for Pain Management, LLC is not a party to this action and that they are entitled to full payment for all services rendered. I further agree that the amount to be paid to Minnesota Institute for Pain Management, LLC will not be lessened in any amount due to a deductible or a settlement for less than 100% of the total amount of damages.
7. I agree to promptly notify Minnesota Institute for Pain Management, LLC of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or additional attorney(s).

Patient Signature:_____ Date:_____

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Minnesota Institute for Pain Management, LLC The undersigned further agrees to hold such sums in trust for the benefit of Minnesota Institute for Pain Management, LLC. In the event the above patient changes attorneys, this lien will be made a part of the file and new counsel will be advised of said lien by the undersigned.

Attorney Signature:_____ Date:_____

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Minnesota Institute for Pain Management
Back and Neck Pain Initial Visit DATE:_____

First Name:_____ Last name:_____ DOB:_____

Current Complaint (Please Type In):_____
(Examples: Neck Pain, Back Pain, Leg Pain, Weakness, Numbness)

Name of the referring Physician: _____ Date of Onset: _____

Is it Work related or Accident related: _____Work Restrictions, if any_____

Describe the pain onset and progression briefly (Also accident/injury-if related):

_____

_____

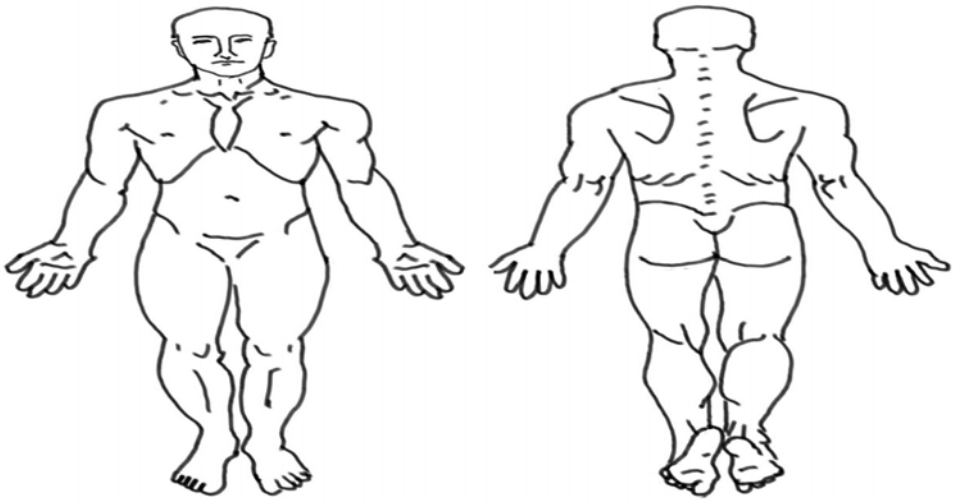
_____

PAIN LOCATION AND PAIN CHARACTER:

Please **MARK** appropriate pain character symbol from below on pain location on the diagram

Numb/Tingling	^^^^	**Burning**	**OOOO**
Sharp	**ZZZ**	**Other**	
Ache	**XXX**		
Stabbing	////		

Handedness R or L



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Please Write in what aggravates pain in your back or neck (Examples: Walking, Changing positions, Sitting Standing, Rolling over, Prolonged positions Bending, lifting):

Please write in what relieves pain in your back or neck(Examples: Sitting , Changing positions, Rest, Lying down, Medications, Therapy):

Please **CHOOSE** from the drop-down pain at onset and pain now (scale of 1-10; 1= no pain 10= worst possible pain)

Back
Onset: 1 **Now**: 1

Neck:
Onset: 1 **Now**: 1

WORK UP (X-rays, MRI etc) Please provide when and where if possible

X-Rays _____ MRI _____

CT scan _____ EMG _____

Bone Scan _____ Discogram _____

TREATMENT TRIED

Medications tried so far: _____

Are you on blood thinners_____

Chiropractic treatment: For how long_____ and last visit_____

Physical Therapy: For how long_____ and last visit_____

Any injections: When _____and what kind of injections_____

Heat or Ice or TENS _____

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Have you seen any other specialist _____

ALLERGIES (Please list your allergies)

_____

_____

CURRENT MEDICATIONS LIST

_____

_____

PAST SURGICAL HISTORY (if applicable)

Please indicate type of surgery, date and physician's name:

1._____

2._____

3._____

Family Medical History:_____

_____

PAST MEDICAL HISTORY (Check all that apply):

- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Atrial Fibrillation
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Benign Prostatic Hypertrophy
- ☐ Cancer
- ☐ Cerebrovascular Accident (Stroke)
- ☐ Congestive Heart Failure (CHF)
- ☐ Coronary Artery Disease
- ☐ COPD (Emphysema)
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Degenerative Joint Disease
- ☐ Depression
- ☐ DVT (Blood Clot)
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ Gout
- ☐ GERD
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hepatitis
- ☐ Heart valve problems
- ☐ Inflammatory Bowel Disease
- ☐ Juvenile Rheumatoid Arthritis
- ☐ Kidney Disease
- ☐ Lyme Disease
- ☐ Liver Disease
- ☐ Myocardial Infarction
- ☐ Multiple Sclerosis
- ☐ Migraine Headaches
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Parkinson Disease
- ☐ Peptic Ulcer Disease
- ☐ Psoriasis
- ☐ PVD
- ☐ Renal Disease
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ SLE (Lupus)
- ☐ Spinal Stenosis
- ☐ Thyroid Disease
- ☐ Valvular Disease
- ☐ None
- ☐ Other

SOCIAL HISTORY

Smoking(yes/no):_____ Alcohol(yes/no):_____ Recreational Drugs(yes/no):_____

Marital Status: _____ Employer: _____

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Brief job physical requirements:

_____
_____
_____

REVIEW OF SYSTEMS

(Please Write In symptoms of last few months)

Constitutional: (Examples:Fever, Chills, Weight loss, Loss of appetite, Trouble sleeping, Night pain)

_____

Dermatology: (Example:Skin rash)_____

Musculoskeletal: (Examples:Arthritis, fibromyalgia, muscle spasms)_____

HEENT: (Examples:Falls, Dizziness, Headaches, Eye redness, glaucoma, vision or hearing difficulties)_____

Neurological: (Examples:Numbness/Tingling, Weakness, Loss of bladder or bowel control, Change in Handwriting)_____

Cognition/Psych: (Examples:Memory difficulties, easily irritability, difficulty concentration, depression, mental disability)_____

Cardiovascular: (Examples:Chest pain, Irregular heart rate/ palpitation)_____

Respiratory: (Examples:Asthma, Shortness of breath, Cough)_____

Hematology: (Examples:Easy bruising or bleeding)_____

Gastrointestinal: (Examples:Constipation, diarrhea, nausea, vomiting, loss of bowel control)_____

Genitourinary: (Examples:Urinary retention, urgency, loss of bladder control)_____

Patient Signature:_____ **Date:**_____

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	☐	☐	☐	☐	☐
2. How often have you felt a need for higher doses of medication to treat your pain?	☐	☐	☐	☐	☐
3. How often have you felt impatient with your doctors?	☐	☐	☐	☐	☐
4. How often have you felt that things are just too overwhelming that you can't handle them?	☐	☐	☐	☐	☐
5. How often is there tension in the home?	☐	☐	☐	☐	☐
6. How often have you counted pain pills to see how many are remaining?	☐	☐	☐	☐	☐
7. How often have you been concerned that people will judge you for taking pain medication?	☐	☐	☐	☐	☐
8. How often do you feel bored?	☐	☐	☐	☐	☐
9. How often have you taken more pain medication than you were supposed to?	☐	☐	☐	☐	☐
10. How often have you worried about being left alone?	☐	☐	☐	☐	☐
11. How often have you felt a craving for medication?	☐	☐	☐	☐	☐
12. How often have others expressed concern over your use of medication?	☐	☐	☐	☐	☐

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	☐	☐	☐	☐	☐
14. How often have others told you that you had a bad temper?	☐	☐	☐	☐	☐
15. How often have you felt consumed by the need to get pain medication?	☐	☐	☐	☐	☐
16. How often have you run out of pain medication early?	☐	☐	☐	☐	☐
17. How often have others kept you from getting what you deserve?	☐	☐	☐	☐	☐
18. How often, in your lifetime, have you had legal problems or been arrested?	☐	☐	☐	☐	☐
19. How often have you attended an AA or NA meeting?	☐	☐	☐	☐	☐
20. How often have you been in an argument that was so out of control that someone got hurt?	☐	☐	☐	☐	☐
21. How often have you been sexually abused?	☐	☐	☐	☐	☐
22. How often have others suggested that you have a drug or alcohol problem?	☐	☐	☐	☐	☐
23. How often have you had to borrow pain medications from your family or friends?	☐	☐	☐	☐	☐
24. How often have you been treated for an alcohol or drug problem?	☐	☐	☐	☐	☐

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PRINT PATIENT's LEGAL NAME:_____ **DOB:**_____
Previous Name(s):_____ **PHONE #:**_____

1) **Please release my records from (Who has your records? Please print Hospital/Clinic name).**

Name:_____

Address:_____ **City:**_____ **State:**_____

Phone:_____ **Fax:**_____

2) **Release the records marked below for this condition or date(s) of treatment:**_____
(If blank, we will release 1 year's worth of most recent records.)
☐ **Pertinent clinic records (office visits, labs/radiology results, medications, immunizations)**
☐ **Pertinent hospital records (emergency, operative or discharge reports, history/physical, labs/ radiology results)**
☐ **X-Ray/Radiology Reports** ☐ **Emergency room/Urgent Care** ☐ **EKG report** _____
☐ **Other - please specify** _____

3) **Please release my records to (Who needs the information? Where does it need to be sent?).**
Name:_____
Phone:_____ **Fax:**_____
Address:_____ **City:**_____ **State:**_____

4) **Delivery format:** ☐ **E-mail** ☐ **Fax** ☐ **USPS** ☐ **Pick up**
5) **Purpose:** ☐ **Continuing Care** ☐ **Insurance** ☐ **Personal Use** ☐ **Legal** ☐ **Other** _____
6) **I understand that:**
The release of records listed in Section 2 may include detailed information of mental health, chemical dependency, genetic conditions, and AIDS/HIV. If I have received treatment for any of these conditions, I do not want the following records released: _____
If I change my mind, I may write to the address in Section 1 to stop the releasing of my records. This will not apple to records that have already been released. Once the records are released to the name above, the place releasing my records cannot prevent them from being shared with a third party. At that point, the records may no longer be protected by the state and federal privacy laws. I approve the release of records for future visits starting from the date I sign this form through(date): _____
A photocopy of this completed, signed form is considered valid o=if not altered. I understand that, except for research related treatment, you will not condition my treatment, payment, enrollment, and or eligibility for benefits on my signing this authorization. This form expires one year after I sign it, or on(date) _____, **except in certain situations specified by law.**

Date:_____

Signature of patient:_____

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Sign & Date Here To Confirm Withdrawal Of Above Consent _____

MINNESOTA INSTITUTE FOR PAIN MANAGEMENT

PATIENT CONSENT TO COMMUNICATE BY EMAIL, TEXT and/or OTHER ELECTRONIC MEANS

I understand and accept that there are significant risks associated with electronic communicaons, including, but not limited to text messages, voicemail, email, and others, including these risks:

- The privacy and security of electronic communicaon cannot be guaranteed.
- Employers and online services may have a legal right to inspect and keep emails passing through their systems.
- Electronic communicaons, including email and text messages, can be intercepted, forwarded, circulated, stored or even changed without the knowledge or permission of either the sender or recipient.
- Copies of an email or a text message may connue to exist, even a. er reasonable efforts to delete the email have been made.
- Someone other than me may send an email or text message in my name, and this impersonaon may not be detected by the recipient.
- Email may carry computer viruses that may damage computer data or sow are or disclose my informaon against my wishes.
- Email or text messages may be accidentally sent to an unintended recipient, or to many such recipients.
- Email or text messages or other forms of electronic communicaon may be disclosed to third pares or to the public, regardless of the intenons of the receiver or sender.

I understand and agree that if the Clinic engages in electronic communicaon with me:

- The Clinic or one or more of my Clinic correspondents may decide to stop doing so, at any me, for their own reasons.
- I must not use email or text messages for medical emergencies or other me-sensiv e ma ers. If I need immediate assistance or have a condion that appears serious or worsens rapidly, I must not rely on email. Instead, I should take other measures as appropriate, which may include seeking emergency services.
- The Clinic may require that I follow addional rules for the use of electronic communicaon that it may set at any me.
- The Clinic may use or disclose my email and/or the informaon in it to people other than the intended recipient, for a variety of purposes—for example, to update my health records, and to permit others to assist in my care or in record-keeping.

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- Although efforts are made to respond mely , the Clinic cannot guarantee that any parcular electronic communicaon will be read and responded to within any parcular me period.
- Neither the Clinic nor those communicang on its behalf will be liable for any harmful consequence to me that may arise from the use of email.
- If I wish to withdraw my consent to communicate by email, I may do so at any me, but I must do so in wring and ensure all relevant email correspondents receive a copy of my withdrawal noce.
- If my email address changes, I shall promptly inform my email correspondents.
- If I feel there is an undue delay in response to an email I send, it is my responsibility to follow up.

I specifically authorize the Clinic to communicate with me in the following ways (check all that apply):

€ Via Email ☐

€ Via Text Message, if necessary and/or applicable ☐

€ Clinic May leave a Voicemail to remind me of an appointment or for other purpose related to my care ☐

Phone Number: _____

My email address is: _____

Patient: _____

Patient DOB:_____

MRN (If Applicable):_____
Signature of Patient:
_____
DATE:_____

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We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable another patient who is waiting for an appointment to be scheduled in that appointment slot.

With cancellations made less than 24 hours notice, it inhibits our ability to offer that slot to other patients. Cancellations made less than 24 hours notice will be considered as **LATE CANCEL**.

Patients who do not show up for their appointment without a call to cancel an appointment will be considered as **NO SHOW**.

Patients may be dismissed from Minnesota Institute for Pain Management, thus they will be denied any future appointments if they:

1. No-Show two (2) times in a 6 month period, **OR**
2. Late Cancel two (2) times in 6 month period, **OR**
3. No-Show one (1) time **and** Late Cancel one (1) time in a 6 month period.

We understand that special, unavoidable circumstances may cause you to cancel within 24 hours. Dismissals in this instance may be waived but only with management approval.

Minnesota Institute for Pain Management firmly believes that good physician/patient relationship is based upon understanding and good communicaon. Quesons about cancellaon and no show policies should be directed to the Front Desk (651-815-8155).

Thank you,

MIPM Management

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I hereby understand the cancellation policy of Minnesota Institute for Pain Management, acknowledging that services may result in dismissal from Minnesota Institute for Pain Management, thus denial of any future appointments, if I:

- No-Show two (2) mes in a 6 month period, **OR**
- Late Cancel two (2) mes in a 6 month period, **OR**
- No-Show one (1) me **and** Late Cancel one (1) me in a 6 month period

Patient Name:_____

Date:_____

Patient Signature:_____