Injury Specialists

10435 Clayton Road, Suite 120
Frontenac MO 63131-2931
Phone: 314-985-3002
Fax: 314-985-3012

Dear Patient,

We appreciate you choosing Injury Specialists and want your visit to be made easier. In your online patient portal, you will find questionnaires to be completed prior to your first visit. When you arrive for your new patient appointment, please bring your insurance cards, test results (any MRI / CT scans performed), information on whom is responsible for your bill, and any other relevant information.

As a courtesy, we will attempt to verify your insurance benefits (provided we are given accurate information), and / or obtain authorization for treatment prior to your visit. If your insurance plan requires a referral, you are responsible for obtaining the referral prior to your visit.

Your cooperation is greatly appreciated and will assist in expediting your initial visit.

Sincerely,
The Physicians and Staff of Injury Specialists
Dr. Barry I. Feinberg, Dr. Rachel A. Feinberg, and Dr. Tong Zhu

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UNDERSTANDING YOUR BILL

It is Injury Specialists' and Frontenac Surgery and Spine Care Center's (FSSCC) policy that all **co-pays and co-insurance** are to be paid at the time of service because of legally binding contracts. After your treatment at Injury Specialists and/or Frontenac Surgery and Spine Care Center, a claim will be submitted to your insurance company for payment of services rendered.

As you prepare for your appointment, we want to make sure you understand how you will be billed for the services you received. *You may receive up to two separate bills*. The success of your treatment depends on a team effort by many dedicated professionals at the two facilities at this location. **Due to government and insurance rules** each facility of our team must send you a separate bill and collect payment from you separately.

Here is an explanation of the bills you may receive:

1. **Injury Specialists – Physician's Bill**
   Your physical assessment, injections, and medication management will be performed by an Injury Specialists physician. At each appointment, your co-pay and/or estimated in-network co-insurance will be collected at the time of service. Your patient statement will be sent from the physician's office – Gateway Pain Center, Inc. DBA Injury Specialists. Questions and payments regarding your Injury Specialists patient statement should be addressed to our billing office at 866-776-8150.

2. **Frontenac Surgery and Spine Care Center**
   Your injections may be performed in the treatment rooms of FSSCC. At each appointment, your co-pay and/or estimated in-network co-insurance will be collected at the time of service. FSSCC will bill you for any remaining in-network portion not paid by your insurance. Questions and payments regarding your FSSCC statement should be addressed to their billing office at 314-699-4356.

We realize that these multiple bills can be confusing. Our staffs will do their very best to help you with questions and guide you to the proper sources of information.

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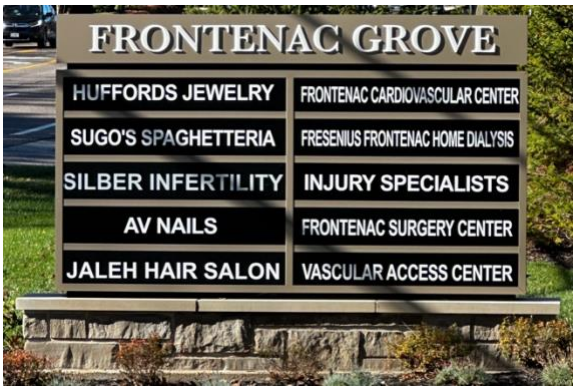
DIRECTIONS

Injury Specialists is located at 10435 Clayton Road, Suite 120, Frontenac MO 63131.

COMING FROM SOUTH

Take I-270 north to I-64. Go right (east) on I-64. Exit at Lindbergh Blvd and make a right going South. Turn right on Clayton Road and Injury Specialists is located on the right (north) side of Clayton Road about ½ mile down in the Frontenac Grove Plaza. We are located in the large brick building at the back of the parking lot. Suite 120 is on the first floor and the entrance is at the east side of the building.



COMING FROM NORTH

Take I-270 south to I-74. Go left (east) on I-64.
Exit at Lindbergh Blvd and make a right going South. Turn right on Clayton Road and Injury Specialists is located on the right (north) side of Clayton Road about ½ mile down in the Frontenac Grove Plaza. We are located in the large brick building at the back of the parking lot. Suite 120 is on the first floor and the entrance is at the east side of the building.

COMING FROM WEST

Take I-64 east to Lindbergh Blvd and make a right going south on Lindbergh. Turn right on Clayton Road and Injury Specialists is located on the right (north) side of Clayton Road about a 1/3 mile down in the Frontenac Grove Plaza. We are located in the large brick building at the back of the parking lot. Suite 120 is on the first floor and the entrance is at the east side of the building.

COMING FROM ILLINOIS

Take I-64 west to Lindbergh Blvd and make a left going south on Lindbergh. Turn right on Clayton Road and Injury Specialists is located on the right (north) side of Clayton Road about a 1/3 mile down in the Frontenac Grove Plaza. We are located in the large brick building at the back of the parking lot. Suite 120 is on the first floor and the entrance is at the east side of the building.

Revised: 11.13.2024

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APPOINTMENT ARRIVAL / CANCELLATION POLICY

When you schedule an appointment with our practice, we set aside enough time to provide you with the highest quality care. ***Should you need to cancel or reschedule an appointment***, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

1. Any **established** patient who fails to show or cancel / reschedule an appointment and has not contacted our office with at least 24 hours' notice will be considered a No Show and charged a ***$25 fee***.
2. Any **established** patient who fails to show or cancels / reschedules an appointment and has not contacted our office with at least 24 hours' notice a **second time** will be considered a No Show and charged a ***$50 fee***.
3. Any **established** patient who fails to show or cancels / reschedules an appointment and has not contacted our office with at least 24 hours' notice a **third time** will be considered a No Show and charged a ***$75 fee***.
4. If a **fourth no show** or cancellation / reschedule with no 24 hour notice should occur, the patient *may be dismissed* from Injury Specialists.
5. Any new patient who fails to show for their initial visit will be charged a $100 fee. If a second no show occurs, the patient will not be rescheduled.

For any cancellation that should occur during the weekend, patient can send email to info@injuryspecialist.com in order to provide a 24 hours' notice. The fee is charged to the patient, not the insurance company, and is due before an appointment is scheduled.

When patient arrives for the appointment, there are forms to be completed. In order to make sure patients are checked in timely, **we ask that all established patients arrive 20 minutes before scheduled appointment time. We ask that all new patients arrive 60 minutes before scheduled appointment time if they have not completed their forms in advance or 20 minutes before scheduled appointment time if they have completed forms in advance**. For specialty practices that often have long wait lists, a patient no-show means that a wait-list patient could have had a spot on the schedule but didn't have the opportunity. Timing and access is everything for our patients.

Injury Specialists

SOAPP =_____ COMM=_____ PMQ-R=_____ CESD-R=_____ GPCOG=_____

PATIENT HISTORY FORM

Please complete all questions on both sides of the form

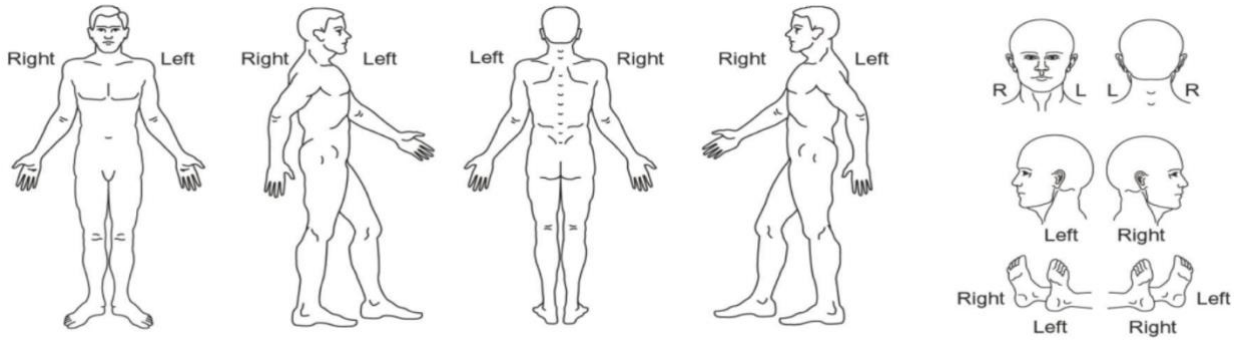
Name:_____ **Age:**_____ **Today's Date:**_____

Whom may we thank for referring you to Injury Specialists?_____

What is the pain that brings you into the office today?_____

When did the pain begin?_____

Shade in the pain location(s):



How did it start? ☐ After an operation or other physical problem ☐ No Apparent Cause

☐ Accident at home ☐ Accident at work ☐ Auto Accident ☐ Other_____

Has it been worsening? ☐ Yes ☐ No

Have you received treatment from any of the following? ☐ Surgeon ☐ Family Doctor

☐ Chiropractor ☐ Physical Therapist ☐ Massage Therapist ☐ Other Pain Doctor

Have you received any prior injections? ☐ Yes ☐ No

List any tests you have had performed (MRI,CT) including when and where:

_____

_____

On a scale of 0 – 10, please rate your pain where 0 = no pain and 10 = worst pain

At its worst:_____ **At its least:**_____ **Usually:**_____ **TODAY:**_____

What best describes your pain?

☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing ☐ Stinging ☐ Tingling

Difficulty sleeping? ☐ Yes ☐ No

List any past operations and/or medical procedures including where and when:

_____

_____

_____

List ALL current medications including dosage & frequency (including over the counter):

_____

_____

_____

_____

_____

_____

List ALL allergies and reactions to each:

_____

_____

_____

Primary Care Physician (PCP) Name:_____

PCP Phone:_____ **PCP Date of Last Visit:**_____

If female:
Are you currently pregnant? ☐ Yes ☐ No

Are you currently breastfeeding? ☐ Yes ☐ No

Date of last PAP smear: _____

Date of last mammogram: _____ **Mammogram Results**: ☐ Normal ☐ Abnormal

If male: Date of Last Prostate Exam:_____

Date of last colonoscopy: _____ **Colonoscopy Results**: ☐ Normal ☐ Abnormal

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation:_____

Work Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Disabled ☐ Retired

Do you use recreational drugs? ☐ Yes ☐ No

If yes, how often?: ☐ Daily ☐ Multiple Times / Week ☐ Weekly ☐ Multiple Times / Month

☐ Monthly ☐ On Occasion

If yes, Drug Type(s): ☐ Cannabis ☐ Cocaine ☐ Fentanyl ☐ GHB ☐ Hallucinogens

☐ Heroin ☐ Inhalants ☐ Ketamine ☐ Kratom ☐ LSD ☐ MDMA ☐ PCP

☐ Methamphetamine ☐ Mushrooms ☐ Steroids ☐ Other_____

Do you smoke? ☐ Yes ☐ No ☐ Not anymore

If yes: How many packs per day?_____ **Number of years smoked:**_____

If not anymore: Date Quit:_____ **How many packs per day**?_____

Number of years smoked:_____

Please select the option that best reflects your alcohol use: ☐ Non Drinker

☐ Occasional Drinker ☐ Moderate Drinker ☐ Heavy Drinker ☐ Recovering Alcoholic

	Cancer	Heart Disease	Diabetes	Alcoholism	Drug Addiction	Hypertension	Connective Tissue Disease	Lung Disease	Other
Mother	☐	☐	☐	☐	☐	☐	☐	☐	
Father	☐	☐	☐	☐	☐	☐	☐	☐	
Sister(s)	☐	☐	☐	☐	☐	☐	☐	☐	
Brother(s)	☐	☐	☐	☐	☐	☐	☐	☐	
Daughter(s)	☐	☐	☐	☐	☐	☐	☐	☐	
Son(s)	☐	☐	☐	☐	☐	☐	☐	☐	

Mother: ☐ Living ☐ Deceased **Father:** ☐ Living ☐ Deceased

Sister(s): #_____ Living **#**_____ Deceased **Brother(s): #**_____ Living **#**_____ Deceased

Daughter(s): #_____ Living **#**_____ Deceased **Son(s): #**_____ Living **#**_____ Deceased

If you will be at least 65 years old at the time of your first visit:

Do you have an Advanced Care Plan? (e.g.- Durable Power of Attorney for Healthcare)

☐ Yes ☐ No. *If yes, please bring a copy of you POA with you for your first visit*

If yes, who is you Surrogate Decision Maker? _____

REVIEW OF SYSTEMS

Please mark all symptoms that apply in each category

Constitutional: ☐ Fever / Chills ☐ Night Sweats ☐ Generalized Pain ☐ Weakness ☐ Lack of Energy ☐ Insomnia ☐ Fatigue ☐ Recent Weight Gain ☐ Recent Weight Loss

Head: ☐ Headache ☐ Facial Weakness ☐ Swelling of the Cheek ☐ Facial Numbness ☐ Sinus Pressure / Pain ☐ Facial Pain ☐ Facial Twitching ☐ Jaw Pain ☐ Pain Behind Ear

Neck: ☐ Lump or Swelling ☐ Neck Stiffness ☐ Muscle Tightness ☐ Swollen Glands ☐ Neck Pain ☐ Muscle spasms ☐ Cracking Sensation Felt ☐ Grating Sensation Felt

Eyes: ☐ Double Vision ☐ Blurred Vision ☐ Itching ☐ Red Eyes ☐ Pain in the eyes ☐ Sensitivity to Light ☐ Discharge ☐ Wears Corrective Lenses ☐ Vision Changes ☐ Vision Distortion

Ear / Nose / Throat: ☐ Nose bleeds ☐ Earache ☐ Nasal Discharge ☐ Mouth Sores ☐ Difficulty Swallowing ☐ Post-Nasal Drip ☐ Nasal Congestion ☐ Hoarseness ☐ Ear Pain ☐ Sore Throat ☐ Gum Bleeding ☐ Hearing Difficulty ☐ Ringing in the Ears

Breast: ☐ Nipple Discharge ☐ Breast Lump(s) ☐ Breast Pain ☐ Change in Breast Skin

Cardiovascular: ☐ Chest Pain ☐ Slow Heart Rate ☐ Fast Heart Rate ☐ Palpitations ☐ Cold Hands & Feet ☐ Arm Swelling ☐ Fast or Irregular Heartbeat ☐ Leg Swelling ☐ High Blood Pressure ☐ Rheumatic Disorders ☐ High Cholesterol

Respiratory: ☐ Cough ☐ Wheezing ☐ Shortness of Breath ☐ Bloody Sputum / Mucus

☐ Sudden Difficulty Breathing ☐ Pneumonia ☐ Asthma Inhaler ☐ Chronic Bronchitis

☐ Emphysema ☐ Using Extra Pillows or Sleeping Upright

Gastrointestinal: ☐ Nausea ☐ Heartburn ☐ Vomiting ☐ Constipation ☐ Bloating

☐ Diarrhea ☐ Bloody Stools ☐ Abdominal Pain ☐ Recurrent Acid Reflux

☐ Bloody Vomit ☐ Change in Bowel Habits

Genitourinary: ☐ Blood in Urine ☐ Urgency ☐ Sexual Difficulty ☐ Frequency

☐ Hesitancy ☐ Waking in the Night to Urinate ☐ Incontinence ☐ Abnormal Bleeding

☐ No Period ☐ Painful Intercourse ☐ Pain During Urination ☐ Prostate Problems

☐ Kidney Stones ☐ Excessive Quantity of Urine ☐ Urethral Discharge

☐ Change in Urinary Habits ☐ Sexually Transmitted Disease ☐ Swelling

Endocrine: ☐ Thyroid Problems ☐ Excessive Thirst ☐ POTS Disease ☐ Heat Intolerance

☐ Cold Intolerance ☐ Flushing ☐ Excessive Sweating ☐ Feeling of Weakness

☐ Hair Loss ☐ Dry Skin ☐ Dry Nails ☐ Diabetes Type I ☐ Diabetes Type II

Musculoskeletal: ☐ Joint Stiffness ☐ Muscle Cramps ☐ Back Pain ☐ Swelling

☐ Pain in Muscles ☐ Joint Pain ☐ Muscle Weakness ☐ Numbness

Neurologic: ☐ Tingling ☐ Memory Lapses or Loss ☐ Lightheadedness ☐ Fainting

☐ Confused or Disoriented ☐ Vertigo ☐ Dizziness ☐ Convulsions / Seizures

☐ Speech Difficulties ☐ Poor Coordination ☐ Burning Sensation ☐ Tremors

Psychiatric: ☐ Anxiety ☐ Depression ☐ Hypersensitivity ☐ Sleep Disturbances

☐ Nervous

Skin: ☐ Rash ☐ Redness of the Skin ☐ Skin Lesions ☐ Itching ☐ Paleness

☐ Change in Skin Texture ☐ Blueness of the Skin ☐ Skin Sore ☐ Lump

Skin: ☐ Yellowness of the Skin (Jaundice) ☐ Localized Skin Discoloration ☐ Skin Bump

Hematology / Immunology: ☐ Easy bleeding/ bruising tendency ☐ HIV exposure

☐ Persistent infections ☐ Immune Deficiency ☐ Strong Allergic Reactions

☐ Environmental Allergies ☐ Other Allergic / Immunologic Symptoms ☐ Cancer

☐ History of Blood Clots ☐ Frequent Infections

Injury Specialists

REGISTRATION FORM

Today's Date: _____
Patients Name: _____ Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F
Street Address: _____ City:_____ State:_____ Zip:_____
Home Phone:_____ Cell Phone: _____ Email Address:_____
Emergency Contact Name: _____ Relationship:_____ Phone:_____

Are you here for injuries sustained in a motor vehicle accident? ☐ NO ☐ YES
Date of accident: _____ State:_____
It is our policy to bill your health insurance for charges relating to all motor vehicles accidents

Are you here for injuries sustained in a work-related accident? ☐ NO ☐ YES
Date of accident: _____ Have you filed a work comp claim? ☐ NO ☐ YES
Claim Number:_____ Contact Person/Employer: _____ Phone: _____

Are you being represented by an attorney? ☐ NO ☐ YES
Name_____ Phone: _____ Fax: _____ Email: _____
Street Address: _____ City:_____ State:_____ Zip:_____

PRIMARY INSURANCE INFORMATION (*HEALTH INSURANCE INFORMATION MUST BE COMPLETED*)
Name of Insurance Company: _____
ID #:_____ Group #_____ Co-pay:$_____
Subscriber's Name: _____ Date of Birth:_____ Relationship to patient: _____

SECONDARY INSURANCE INFORMATION
Name of Insurance Company: _____
ID #:_____ Group #_____ Co-pay:$_____
Subscriber's Name: _____ Date of Birth:_____ Relationship to patient: _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance benefits and assign directly to **Gateway Pain Center, DBA Injury Specialists** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Gateway Pain Center, DBA Injury Specialists** to release all information necessary to secure the payment of benefits. I authorize the use of my signature for all my insurance submissions. *I authorize **Gateway Pain Center, DBA Injury Specialists** to release a copy of this form to **Frontenac Surgery & Spine Care Center** for insurance verification purposes in the event that I am referred to their facility for treatment. I also understand that if treated at **Frontenac Surgery & Spine Care Center**, I will receive a separate bill for the facility.*

Signature of Insured/Guardian:_____ Date:_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Gateway Pain Center, DBA Injury Specialists** for any services furnished to me by **Gateway Pain Center, DBA Injury Specialists**. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of Information to the insurer or agency shown. In Medicare assigned cases, the physicians or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare Carrier.

Beneficiary Signature: _____ Date: _____

FINANCIAL POLICIES

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policies is important to our practice. Please ask us if you have any questions about our fees, policies or your financial responsibility.

All new patients are asked to complete our Patient Registration Form before seeing the doctor. We request our established patients to inform us of any changes in name, address, phone number, employer and/or insurance status.

Based on your insurance benefits, your copay **must be paid** for all routine office visits, new patient visits and med checks. Because our physicians are considered specialists, a higher copay may be required. Again, please check with your insurance company to verify this information. We accept cash, checks, money orders, Visa, Mastercard, Discover and American Express. If the copay cannot be paid at the time of service, our office will assist you with rescheduling your appointment for a more financially convenient time for you.

Insurance

It is important to check your insurance plan in detail prior to your visit. If any information has been updated or changed, please tell us before being seen by the doctor.

Many HMOs require a written referral or a referral number for the specialty care provided in our office. Please make all necessary arrangements to obtain a referral **prior** to your visit. If a referral is required, but not obtained, you may reschedule your appointment when you have the necessary information needed for your visit.

As a courtesy to you, this office will file insurance claims for professional services rendered. After an insurance claim has been processed and payment and/or an explanation of benefits (EOB) has been sent, you are responsible for all coinsurance, deductible, non-covered services and all unpaid services as specified by the EOB you receive.

Following your treatment, the processing of your insurance claim and receipt of an EOB, you will be sent a patient statement from our office. Upon receipt, **ALL** of the patient balance due must be paid timely, as communicated on the patient statement you receive. You can make the required payment by mail, online as indicated on the patient statement or by calling our billing office at the number listed on the statement. If you have difficulty in making the required payment, please call our billing office to discuss payment options. If you don't make an attempt to settle what is owed, then your account may be turned over to a collection agency and may be subject to a monthly finance charge of 1.50% ($0.50 minimum) and/or a 25% collection fee. In this process, you are authorizing us to contact you by phone, mail, email and text communications as necessary.

Work-Related Injuries

If you have a work-related injury or a lawsuit is involved, all visits and treatments must be approved by the Worker's Compensation agent or attorney assigned to your case. **Please be sure to have this information** (adjuster's name, phone number, worker's compensation case number, date of accident and claims mailing address) prior to your **first** visit so that we may make arrangements accordingly. If your employer has approved treatment, you will not be billed at this time. If your employer **does not** approve treatment and **you select us for your treatment**, you will be held responsible for all charges accrued.

If involved in an automobile accident, it is policy that we bill your employer's medical insurance. We **DO NOT** have contractual agreements with any automobile insurance companies.

If you are represented by an attorney for a work related or automobile accident, then we will require the attorney's name, address and phone number.

I understand that if I receive an injection or other services performed at Frontenac Surgery and Spine Care Center, I will receive a separate bill for those services.

Physician Financial Ownership Disclosure

We are required by Federal law to notify you that the physicians in this practice have financial interests or ownership in Frontenac Surgery and Spine Care Center, an ambulatory surgery center (ASC). We are required by 42 C.F.R. § 416.50 to disclose this financial interest or ownership in writing prior to any procedure(s) provided to you.

The physicians having a financial interest in this ASC are listed below:

1. Dr. Barry Feinberg
2. Dr. Rachel Feinberg
3. Dr. Tong Zhu

Print Name: _____ Signature: _____

Date: _____ Relationship to Patient: _____
(Self or Responsible Party if patient is a minor or unable to sign)

AUTHORIZATION FOR RELEASE OF INFORMATION

SECTION A

Release of Medical Records to Injury Specialists

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. Injury Specialists does not release secondary patient records (patient records sent to Injury Specialists for review).

Patient Name:_____

Social Security Number:_____ Date of Birth:_____

Persons / Organizations providing the information:

_____

_____

_____

Persons / Organizations receiving the information:

Injury Specialists
10435 Clayton Road, Suite 120
Frontenac, MO 63131
Telephone: (314) 985-3002
Fax: (314) 985-3012

SECTION B

Please Read Carefully:

I understand that this authorization will expire one year from the date below.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, except to the extent the organization has taken action in reliance on the consent.

Print Name: _____ Signature: _____

Date: _____ Relationship to Patient: _____

(Self or Responsible Party if patient is a minor or unable to sign)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

CONCURRENT TREATMENT

I understand that I must notify INJURY SPECIALISTS if I am currently receiving medical treatment from another facility / doctor.

If, at a later date, I choose to receive these services at another facility, I must notify my doctor or a staff member at INJURY SPECIALISTS.

Print Name: _____ Signature: _____

Date: _____ Relationship to Patient: _____

(Self or Responsible Party if patient is a minor or unable to sign)

Witness Name:_____ Witness Signature:_____

CONSENTS AND POLICIES FOR RELEASE OF INFORMATION

CONSENT FOR RELEASE OF INFORMATION TO INSURANCE PLAN AND ASSIGNMENT OF BENEFITS:
I give my consent to Injury Specialists, Barry Feinberg MD, Rachel Feinberg MD, Tong Zhu MD, to release medical information to my insurance carrier(s), managed care company(ies), Employee Assistance Program(s) or their representatives concerning my illness and treatments. I certify that the information I have reported with regard to my insurance coverage is correct. I give consent for the release of any necessary medical information for this or any related claims, in writing (i.e. treatment plans) or verbally (i.e., requesting benefit authorization information by phone) or electronically (i.e., requesting benefits / authorization information electronically). I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided. It is customary to pay for services when rendered unless other arrangements have been made in advance with the Operations Manager. I agree to pay any additional charges related to the costs of collection (including but not limited to collection agency fees, court costs, and attorney fees) in the event I fail to pay my bills. If any insurance company limits visits I accept responsibility for monitoring the number of allowed sessions used. I agree to pay for all non-covered services including late cancellations / missed appointments, services provided after benefit exhaustion, and services determined not to be necessary by my insurance carrier. I permit a copy of this consent to be used in place of the original.

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION FOR TREATMENT:
I give my consent to treatment by Injury Specialists, Barry Feinberg MD, Rachel Feinberg MD, Tong Zhu MD. I permit a copy of this consent to be used in place of the original. I give my consent to Injury Specialists, Barry Feinberg MD, Rachel Feinberg MD, Tong Zhu MD to utilize electronic health records / electronic medical records (i.e., medical record documentation, etc.) and electronic practice management functions (i.e., billing, claims payment, etc.) in the delivery of my healthcare. I permit a copy of this consent to be used in place of the original. I give my consent to Injury Specialists, Barry Feinberg MD, Rachel Feinberg MD, Tong Zhu MD to release health information by mail, phone, fax, or electronically to staff at my pharmacy and receive information from staff at my pharmacy for purposes of prescribing medication or clarifying medication issues. I permit a copy of this consent to be used in place of the original. I give my consent to Injury Specialists, Barry Feinberg MD, Rachel Feinberg MD, Tong Zhu MD to release health information by mail, phone, fax, or electronically to staff at laboratories and to receive information from staff at laboratories (i.e., Quest, LabCorp, hospital labs, etc.) for the purpose of providing laboratory services and sending laboratory orders and receiving laboratory results. I permit a copy of this consent to be used in place of the original. I give my consent to Injury Specialists, Barry Feinberg MD, Rachel Feinberg MD, Tong Zhu MD to share necessary health information with each other when I am seeing more than one provider at Injury Specialists for healthcare services. I may revoke this consent at any time in writing. I also understand that I will not be able to revoke this authorization is cases where the provider has already relied on it to use or disclose my health information. I permit a copy of this consent to be used in place of the original.

CONSENT FOR RELEASE OF INFORMATION FOR APPOINTMENT REMINDERS, TREATMENT ALTERNATIVES / RECOMMENDATIONS OR HEALTH-RELATED SERVICES:
I give my consent to treatment by Injury Specialists, Barry Feinberg MD, Rachel Feinberg MD, Tong Zhu MD to contact me verbally by phone or electronically by phone for appointment reminders, treatment alternatives / recommendations, or health-related services. I permit a copy of this consent to be used in place of the original.

POLICY FOR RELEASE OF INFORMATION IN SPECIAL SITUATIONS:

I understand and accept that Injury Specialists, Barry Feinberg MD, Rachel Feinberg MD, Tong Zhu MD may disclose health information about me in the event of a serious threat to the health and safety of myself or others, in the event of suspected child abuse or neglect, or in other situations as detailed in the Notice of Privacy Practices. I permit a copy of this policy acknowledgement to be used in place of the original.

POLICY REGARDING LATE CANCELLATIONS / MISSED APPOINTMENTS:

I understand and accept that if I miss a scheduled appointment or if I cancel an appointment with less than 24 hours notice (message may be left on voicemail if after hours or on the weekend 24 hours a day / 7 days a week but would need to occur 24 hours prior to the scheduled appointment time), I am responsible for the missed appointment fee for that appointment. I understand that insurance companies do not pay fees for missed appointments or late cancellations. I understand that this policy applies to illness, injuries, work problems, childcare problems, and other last-minute obligations. The only exemption is a regional weather emergency. I permit a copy of this policy acknowledgement to be used in place of the original.

POLICY FOR EMERGENCY CONTACT:

I understand and accept that if I have a medical emergency, I should contact my provider at Injury Specialists, Barry Feinberg MD, Rachel Feinberg MD, Tong Zhu MD – but if I am unable to reach my provider, I should call 911 or go to the nearest emergency room. I permit a copy of this policy acknowledgement to be used in place of the original.

Print Name: _____ Signature: _____

Date: _____ Relationship to Patient: _____

(Self or Responsible Party if patient is a minor or unable to sign)

Patient DOB:_____

Witness Name:_____ Witness Signature:_____

Date:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USE AND DISCLOSURE OF HEALTH INFORMATION:

Without your consent, we may use health information about you for treatment (such as sending your medical record information to a specialist physician as part of a referral), to obtain payment for treatment (such as sending billing information to a health insurance plan), and for administrative purposes (such as comparing patient data to improve treatment methods).

We may also use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, abuse or neglect reporting, auditing purposes, research studies, coroners, funeral arrangements and organ donations, workers compensation purposes, judicial / administrative proceedings, specialized governmental functions and emergencies. We may also disclose identifiable health information to your relatives or friends involved in your treatment or payment for your treatment. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. We may also contact you to leave you messages about appointment reminders or treatment alternatives. In any other situation, we will ask for your written authorization before using or disclosing an identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change out policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area, in each examination room, and on our web site as applicable. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the Privacy Officer at privacy@injuryspecialist.com.

INDIVIDUAL RIGHTS:

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about your care. You also have the right to receive a limited list of instances where we have disclosed health information about you. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add missing information.

You have the right to request that your health information be communicated to you in a confidential manner such as sending mail to an address other than your home. If this notice was sent to you electronically, you may obtain a paper copy of the notice.

You may request in writing that we not use or disclose your information for treatment, payment, or administrative purposes. We will consider your request but are not required to accept it.

COMPLAINTS:

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you

with the appropriate address upon request. Under no circumstances will you be retaliated again for filing a complaint.

OUR LEGAL DUTY:

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints regarding privacy, please contact our Privacy Officer at privacy@injuryspecialist.com.

Print Name: _____ Signature: _____

Date: _____ Relationship to Patient: _____

(Self or Responsible Party if patient is a minor or unable to sign)

PAIN MANAGEMENT AGREEMENT

Opioids and controlled substances may be used to treat chronic pain. **THEY ARE STRICTLY REGULATED BY STATE AND FEDERAL AGENCIES.**

I, _____, accept the following:
(Full Name)

1. I am reading and making this agreement while in full possession of my faculties.
2. I have been informed of the risks and benefits of the use of controlled substances, including the risk of tolerance and drug dependency.
3. When I need to stop taking the medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms.
4. I agree not to share, sell or otherwise permit others, including my family and friends, to have access to these medications.
5. If my prescription is lost, misplaced or stolen, or if I "run out early", I understand that **it will not be replaced.**
6. I give my permission to discuss all diagnostic and treatment details with dispensing pharmacies or other professionals who provide my health care for purposes of maintaining accountability.
7. I understand that it may be dangerous for me to operate an automobile or other machinery while using any medications and I may be impaired during all activities, including work.
8. (FOR FEMALES OF CHILDBEARING AGE) I also understand that if I become pregnant, or I suspect I am pregnant, I will notify the staff of the office. I accept that any medication may cause harm to the embryo / fetus / baby and hold the clinic and all staff harmless for injuries to the embryo / fetus / baby. Potential risk factors include, low birth weight, premature birth weight, neonatal death, hypoxic ischemic (brain injury), prolonged QT syndrome, and neonatal opioid withdrawal syndrome.
9. I accept that random drug testing may be done at the discretion of Injury Specialists.
10. I may be discharged, in accordance with practice standards, from treatment at any time, **per physician discretion**.
11. I will not receive controlled substances or medication (i.e.: narcotics, muscle relaxers, sleeping pills, anti-anxiety, and / or antidepressants) that may be prescribed at Injury Specialists from any other physician / clinic / hospital / emergency room. And if doing so due to a medical emergency, I will notify Injury Specialists immediately.
12. I will be seen within a 30-day cycle or more often if required to acquire any medication refills. It is my responsibility to schedule my appointment prior to needing my medications refilled. I understand partial refills will no longer be supplied.

Print Name: _____ Signature: _____ Date:_____

Guardian Name: _____ Guardian Signature: _____ Date:_____
(If Patient is a minor)

CONSENT VALID FOR 365 DAYS FROM DATE OF SIGNATURE

Injury Specialists

PATIENT COUNSELING DOCUMENT FOR PATIENTS TAKING OPIOIDS

Opioids and controlled substances may be used to treat chronic pain. **THEY ARE STRICTLY REGULATED BY STATE AND FEDERAL AGENCIES.**

I, _____, accept the following:
(Full Name)

Risk factors of opioid use:

- Addiction / dependence
- Respiratory depression
- Symptoms may increase with the use of benzodiazepine
- Prolonged QT syndrome (abnormal heart rhythm)
- Urinary retention
- Constipation
- Mental status change including fatigue, decreased libido, hormonal change, and low testosterone
- Dental problems
- hypothyroidism

Print Name: _____ Signature: _____ Date:_____

Guardian Name: _____ Guardian Signature: _____ Date:_____
(If Patient is a minor)

CONSENT VALID FOR 365 DAYS FROM DATE OF SIGNATURE

Revised: 08.20.2024

Name:_____ 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.

Please answer the questions using the following scale:	NEVER	SELDOM	SOME-TIMES	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?	☐	☐	☐	☐	☐

Please answer the questions using the following scale:	NEVER	SELDOM	SOME-TIMES	OFTEN	VERY OFTEN
	0	1	2	3	4
12. How often have others expressed concern over your use of medication?	☐	☐	☐	☐	☐
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?	☐	☐	☐	☐	☐

Name:_____ Signature:_____ Date:_____

COMM™

Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past 30 days**. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	**NEVER**	**SELDOM**	**SOME-TIMES**	**OFTEN**	**VERY OFTEN**
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	☐	☐	☐	☐	☐
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	☐	☐	☐	☐	☐
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	☐	☐	☐	☐	☐
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	☐	☐	☐	☐	☐
5. In the past 30 days, how often have you seriously thought about hurting yourself?	☐	☐	☐	☐	☐
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	☐	☐	☐	☐	☐
7. In the past 30 days, how often have you been in an argument?	☐	☐	☐	☐	☐

Please answer the questions using the following scale:	NEVER	SELDOM	SOME-TIMES	OFTEN	VERY OFTEN
	0	1	2	3	4
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	☐	☐	☐	☐	☐
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	☐	☐	☐	☐	☐
10. In the past 30 days, how often have you been worried about how you're handling your medications?	☐	☐	☐	☐	☐
11. In the past 30 days, how often have others been worried about how you're handling your medications?	☐	☐	☐	☐	☐
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	☐	☐	☐	☐	☐
13. In the past 30 days, how often have you gotten angry with people?	☐	☐	☐	☐	☐
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	☐	☐	☐	☐	☐
15. In the past 30 days, how often have you borrowed pain medication from someone else?	☐	☐	☐	☐	☐
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	☐	☐	☐	☐	☐
17. In the past 30 days, how often have you had to visit the Emergency Room?	☐	☐	☐	☐	☐

Injury Specialists

10435 Clayton Road Suite 120
Frontenac, MO 63131
Phone: 314-985-3002
Fax: 314-985-3012

Assessments Billing

The attached assessments are a separate service billed to your insurance company.

Any deductibles, coinsurance or copays will be in addition to today's services.

Your signature below indicates that you were made aware of these charges.

Signature:_____ Date:_____

NOTE: If you should decline to take these assessments, Injury Specialists will NOT be able to prescribe medications for you.

Name:_____ Signature:_____ Date:_____

CESD-R Assessment

Below is a list of the ways you might have felt or behaved. Please check the boxes to tell us how often you have felt this way in the past week or so.	**Not at all or less than 1 Day**	**1 – 2 Days**	**3 – 4 Days**	**5 – 7 Days**	**Nearly every day for 2 weeks**
	0	*1*	*2*	*3*	*4*
1. My appetite was poor.	☐	☐	☐	☐	☐
2. I could not shake off the blues.	☐	☐	☐	☐	☐
3. I had trouble keeping my mind on what I was doing.	☐	☐	☐	☐	☐
4. I felt depressed.	☐	☐	☐	☐	☐
5. My sleep was restless.	☐	☐	☐	☐	☐
6. I felt sad.	☐	☐	☐	☐	☐
7. I could not get going.	☐	☐	☐	☐	☐
8. Nothing made me happy.	☐	☐	☐	☐	☐
9. I felt like a bad person.	☐	☐	☐	☐	☐
10. I lost interest in my usual activities.	☐	☐	☐	☐	☐
11. I slept much more than usual.	☐	☐	☐	☐	☐
12. I felt like I was moving too slowly	☐	☐	☐	☐	☐
13. I felt fidgety.	☐	☐	☐	☐	☐
14. I wished I were dead.	☐	☐	☐	☐	☐
15. I wanted to hurt myself.	☐	☐	☐	☐	☐
16. I was tired all the time.	☐	☐	☐	☐	☐
17. I did not like myself.	☐	☐	☐	☐	☐
18. I lost a lot of weight without trying to.	☐	☐	☐	☐	☐
19. I had a lot of trouble getting to sleep.	☐	☐	☐	☐	☐
20. I could not focus on the important things.	☐	☐	☐	☐	☐

Name:_____ Signature:_____ Date:_____

PMQ-R

In order to develop the best treatment plan for you, we want to understand your thoughts, needs and experiences related to pain medication. Please read each statement below and indicate how much it applies to you by marking your response to each question.

Please answer the questions using the following scale:	**NEVER**	**OCCASS-IONALLY**	**SOME-TIMES**	**OFTEN**	**ALWAYS**
	0	1	2	3	4
1. I believe that I am receiving enough medication to relieve my pain.	☐	☐	☐	☐	☐
2. My doctor spends enough time talking to me about my pain medication during appointments.	☐	☐	☐	☐	☐
3. I would feel better with a higher dosage of my pain medication.	☐	☐	☐	☐	☐
4. In the past, I have had some difficulty getting the medication I need from my doctor(s).	☐	☐	☐	☐	☐
5. I wouldn't mind quitting my current pain medication and trying a new one, if my doctor recommends it.	☐	☐	☐	☐	☐
6. I have clear preferences about the type of pain medication I need.	☐	☐	☐	☐	☐
7. Family members seem to think that I may be too dependent on my pain medication.	☐	☐	☐	☐	☐
8. It is important to me to try ways of managing my pain in addition to the medication (ex: relaxation, physical therapy, TENS unit, etc.)	☐	☐	☐	☐	☐
9. At times, I take my pain medication when I feel anxious and sad, or when I need help sleeping.	☐	☐	☐	☐	☐
10. At times, I drink alcohol to help control my pain.	☐	☐	☐	☐	☐
11. My pain medication makes it hard for me to think clearly sometimes.	☐	☐	☐	☐	☐

Source: Adams, L. L., Gatchel, R. J., Robinson, R. C., Polatin, P., Gajraj, N., & Deschner, M., et al. (2004). Development of a self-report screening instrument for assessing potential opioid medication misuse in chronic pain patients. Journal of Pain and Symptom Management, 27, 440-459.

Please answer the questions using the following scale:	NEVER	OCCASS-IONALLY	SOME-TIMES	OFTEN	ALWAYS
	0	1	2	3	4
12. I find it necessary to go to the emergency room to get treatment for my pain.	☐	☐	☐	☐	☐
13. My pain medication makes me nauseated and constipated sometimes.	☐	☐	☐	☐	☐
14. At times, I need to borrow pain medication from friends or family to get relief.	☐	☐	☐	☐	☐
15. I get pain medication from more than one doctor in order to have enough medication for my pain.	☐	☐	☐	☐	☐
16. At times, I think I may be too dependent on my pain medication.	☐	☐	☐	☐	☐
17. To help me out, family members have obtained pain medication for me from their own doctors.	☐	☐	☐	☐	☐
18. At times, I need to take pain medication more often than it is prescribed in order to relieve my pain.	☐	☐	☐	☐	☐
19. I save my unused pain medication I have in case I need it later.	☐	☐	☐	☐	☐
20. I find it helpful to call my doctor or clinic to talk about how my pain medication is working.	☐	☐	☐	☐	☐
21. At times, I run out of pain medication early and have to call my doctor for refills.	☐	☐	☐	☐	☐
22. I find it useful to take medications (such as sedatives) to help my pain medication work better.	☐	☐	☐	☐	☐
23. How many painful conditions (injured body parts or illnesses) do you have?	☐ 1 painful condition	☐ 2 painful conditions	☐ 3 painful conditions	☐ 4 painful conditions	☐ 5+ painful conditions

Source: Adams, L. L., Gatchel, R. J., Robinson, R. C., Polatin, P., Gajraj, N., & Deschner, M., et al. (2004). Development of a self-report screening instrument for assessing potential opioid medication misuse in chronic pain patients. Journal of Pain and Symptom Management, 27, 440-459.

Please answer the remaining questions using the following scale:	NEVER	1 TIME	2 TIMES	3 TIMES	4+ TIMES
	0	1	2	3	4
24. How many times in the past year have you asked your doctor to increase your prescribed dosage of pain medication in order to get relief?	☐	☐	☐	☐	☐
25. How many times in the past year have you run out of pain medication early and had to request an early refill?	☐	☐	☐	☐	☐
26. How many times in the past year have you accidently misplaced your prescription for pain medication and had to ask for another?	☐	☐	☐	☐	☐

Source: Adams, L. L., Gatchel, R. J., Robinson, R. C., Polatin, P., Gajraj, N., & Deschner, M., et al. (2004). Development of a self-report screening instrument for assessing potential opioid medication misuse in chronic pain patients. Journal of Pain and Symptom Management, 27, 440-459.