Injury Specialists

Helping People Live Better Lives....

Barry I. Feinberg, M. D. | Rachel A. Feinberg, M.D. | Tong Zhu, M.D.
314-985-3002 – 10435 Clayton Road – Suite 120 – Frontenac MO 63131-2931

Dear Patient,

We appreciate you choosing Injury Specialists and want your visit to be made easier. Therefore, below you will find documents to be completed prior to your first visit. When the documents are completed bring them with you along with information on whom is responsible for your bill, your insurance cards, test results (**any mri/ct scan reports performed, blood work, x-ray pictures**), 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

Injury Specialists

FRONTENAC SURGERY & SPINE CARE CENTER

APEXNETWORK. PHYSICAL THERAPY live life.

UNDERSTANDING YOUR BILL

It is Injury Specialists', Frontenac Surgery & Spine Care Center (FSSCC) and ApexNetwork Physical Therapy 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, Frontenac Surgery & Spine Care Center and/or ApexNetwork Physical Therapy, 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 three separate bills*. The success of your treatment depends on a team effort by many dedicated professionals at the three 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:

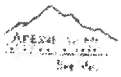
1. **INJURY SPECIALISTS - PHYSICIAN'S BILL**

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 (doing business as) Injury Specialists.*** Questions and payments regarding your Injury Specialists patient statement should be addressed to our billing office at 1-800-596-5387.

2. **FRONTENAC SURGERY & SPINE CARE CENTER**

Your injections are performed in the treatment rooms of **FSSCC**. A $60.00 **deposit** toward your patient balance is 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 our billing office at 314-993-2222.

3. **APEXNETWORK PHYSICAL THERAPY**



Your physical therapy will be performed by licensed physical therapists through ApexNetwork Physical Therapy. At each appointment your co-pay and/or estimated patient responsibility will be collected and ApexNetwork Physical Therapy will bill you for any remaining portion not paid by your insurance. Your patient statement will be sent from ApexNetwork Physical Therapy. Questions and payments regarding your **ApexNetwork Physical Therapy** patient statement should be addressed to our billing office at 1-618-651-0444 option 4.

When you receive check(s) with an explanation of benefits (EOB) from your insurance for services performed at one of our facilities, please endorse the check(s) over to the appropriate facility and then mail the check along with your EOB, as soon as possible to the facility.

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.

Directions

Injury Specialists

10435 Clayton Road Suite 120

St. Louis, MO 63131

314-985-~~3012~~ 3002

Office Hours: Monday-Thursday 7:30 am to 5 pm; Friday 7:30 am to 4 pm

COMING FROM SOUTH

Take I-270 north to I-64. Go right (east) on I-64. Go to Lindbergh Blvd. and make a right going South. Turn right on Clayton Road and Injury Specialist is located on the right (north) side of Clayton Road about a 1/3 mile down in the Frontenac Grove Plaza. The address is 10435 and it is the large brick building at the back of the parking lot. Injury Specialists, 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-64. Go left (east) on I-64 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. The address is 10435 and it is the large brick building at the back of the parking lot. Injury Specialists, Suite 120 is on the first floor and the entrance is at the east side of the building.

COMING FROM WEST

Take Highway 40 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. The address is 10435 and it is the large brick building at the back of the parking lot. Injury Specialists, Suite 120 is on the first floor and the entrance is at the east side of the building.

COMING FROM ILLINOIS

Take I-64/40 west to Lindbergh Blvd. and make a left turn 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. The address is 10435 and it is the large brick building at the back of the parking lot. Injury Specialists, Suite 120 is on the first floor and the entrance is at the east side of the building.

Injury Specialist appointment arrival/cancelation policy

Thank you for trusting Injury Specialists with your medical care. 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. Please see our Appointment Cancellation/No Show Policy below:

Effective September 20, 2021

1. Any **established** patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a No Show and charged a $25.00 fee.
2. Any **established** patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a **second time** will be charged a $50.00 fee.
3. Any **established** patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a **third time** will be charged a $75.00 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 $100.00 fee. If a second No show occurs, patient will not be rescheduled.

For any cancelation that should occur during the weekend, patient can send email to sterzic@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 next 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 15 minutes before scheduled appointment time or will have to be rescheduled.** We ask that all **new patients arrive 30 minutes before scheduled appointment time**.

"For specialty practices that often have long wait lists, a patient no-show means that a wait-list patient has been waiting too long to see a physician and more importantly, could have had a spot on the schedule, but didn't have the opportunity. Timing and access is everything for our patients."

Injury Specialists

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

PATIENT HISTORY FORM

Please complete all questions on both sides of form

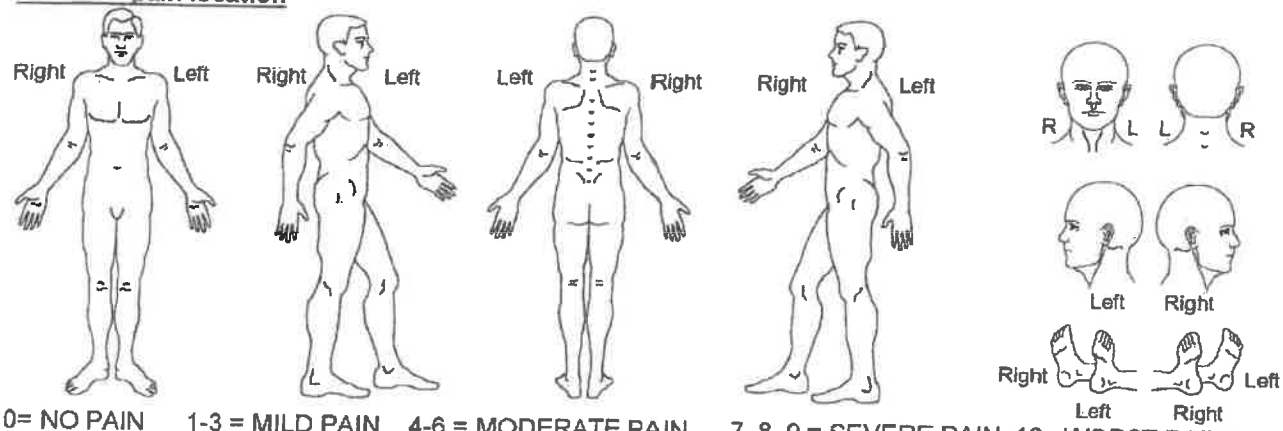
Your Name: _____ Age: _____

Whom may we thank for referring you to Injury Specialists? : _____ Today's Date:_____

When did this pain begin? Month_____ Year_____ How did it start? _____ accident at home ____accident at work _____Auto accident _____After an operation or other physical problem _____No Apparent Cause

Height_____ Weight_____ B/P:_____ Pulse_____ RR_____

Shade in pain location



0= NO PAIN 1-3 = MILD PAIN 4-6 = MODERATE PAIN 7, 8, 9 = SEVERE PAIN 10= WORST PAIN IN YOUR LIFE

Does not affect activity Moderate decrease in activity Limits most activities

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

At Its Worst: _____ At Its Least: _____ Usually: _____ TODAY: _____

Please explain the Main Complaint which brought you to Injury Specialists: _____

_____

_____

Explain what occurred: _____

_____

_____

Explain how your pain feels to you (i.e.; sharp, dull, aching, throbbing, stinging, tingling, etc):_____

Has this pain changed since it began (i.e.; worse or better)? ___No ___Yes **If yes, explain:**_____

What makes your pain feel better? (sitting, standing, lying, etc)_____

What makes your pain feel worse? _____

Is your pain? ___rarely present ___only occurs under certain circumstances ___frequently present ___always present

Have you received treatment from: ____Surgeon _____Family Doctor _____Chiropractor _____Physical Therapi _____Massage Therapist *(check all that apply)*

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

_____

_____

_____

List any tests you have had performed: (MRI, CT Scan, X-rays, Blood work) **including when and where:**

_____

_____

List ***ALL* CURRENT** Medications including dosage and frequency; **(include over the counter medications) PLEASE DO NOT ATTACH LIST**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

LIST ALL ALLERGIES AND REACTION TO EACH:

_____

Primary Care Physician's Name: _____ Telephone Number: _____Date of last visit _____

Date of last Mammogram: ____ normal/abnormal? Date of last Pap Smear: _____ Date of last Flu Shot_____

Date of last Colonoscopy: _____normal/abnormal? Date of last Prostate Exam_____ Date of last Pneumonia Shot____

Date of last Blood Work: _____ Any Difficulty Sleeping? YES or NO

Marital Status: ____Married ____Single _____Divorced ____Widowed ____Separated

Occupation: _____Retired_____ **(please state previous occupation)**

Work Status (Circle): Full Time Part Time Unemployed Disabled

Do you use Recreational Drugs? Y/N Type_____ How often____ **Are you currently Pregnant? ___No ___Yes - # of months**

Tobacco Use:
___Never Smoker
___Current Smoker
___Former Smoker
Number of years smoked____
How many packs per day____
Date Quit Smoking_____

Alcohol Use:
___Non Drinker
___Occasional Drinker
___Moderate Drinker
___Heavy Drinker
___Recovering Alcoholic

FAMILY HISTORY **Diseases/Medical Conditions of EACH**

Mother:_____Living ____Deceased AGE: _____ _____

Father: _____Living ____Deceased AGE: _____ _____

Sister(s):____Living ____Deceased #____ _____

Brother(s):____Living ____Deceased#____ _____

Children ____Living ____Deceased# ____ _____

Number of children: _____ Boys: _____ Girls: _____

Injury Specialists Review of Systems

Constitutional

- ☐ ☐ fever
- ☐ ☐ chills
- ☐ ☐ recent change in weight gain/loss? How much?
- ☐ ☐ loss of appetite
- ☐ ☐ nights sweats
- ☐ ☐ lethargy (lack of energy)
- ☐ ☐ insomnia (trouble sleeping)
- ☐ ☐ increased appetite
- ☐ ☐ fatigue
- ☐ ☐ weakness (malaise)
- ☐ ☐ generalized pain

Head

- ☐ ☐ headache
- ☐ ☐ facial numbness
- ☐ ☐ facial twitching
- ☐ ☐ pain behind the ear
- ☐ ☐ facial weakness
- ☐ ☐ sinus pressure
- ☐ ☐ jaw pain
- ☐ ☐ swelling of the cheek
- ☐ ☐ facial pain
- ☐ ☐ sinus pain

Neck

- ☐ ☐ neck pain
- ☐ ☐ swollen glands
- ☐ ☐ cracking sensation felt
- ☐ ☐ neck stiffness
- ☐ ☐ lump or swelling
- ☐ ☐ grating sensation felt
- ☐ ☐ muscle tightness
- ☐ ☐ muscle spasms

Eye

- ☐ ☐ double vision
- ☐ ☐ red eyes
- ☐ ☐ mucous discharge
- ☐ ☐ vision changes
- ☐ ☐ blurred vision
- ☐ ☐ pain in the eyes
- ☐ ☐ discharge of pus
- ☐ ☐ vision distortion
- ☐ ☐ itching
- ☐ ☐ sensitivity to light
- ☐ ☐ wears corrective lenses

ENMT

- ☐ ☐ nose bleeds
- ☐ ☐ mouth sores
- ☐ ☐ nasal congestion
- ☐ ☐ sore throat
- ☐ ☐ hearing difficult
- ☐ ☐ earache
- ☐ ☐ difficulty swallowing
- ☐ ☐ hoarseness
- ☐ ☐ gum bleeding
- ☐ ☐ ringing in the ears
- ☐ ☐ nasal discharge
- ☐ ☐ post nasal drip
- ☐ ☐ excruciating ear pain
- ☐ ☐ sinus problems

Breasts

- ☐ ☐ nipple discharge
- ☐ ☐ change in breast skin
- ☐ ☐ breast lump
- ☐ ☐ breast pain

Injury Specialists Review of Systems

Cardiovascular

- ☐ ☐ chest pain
- ☐ ☐ palpitations
- ☐ ☐ upper extremity edema
- ☐ ☐ lower extremity eduma
- ☐ ☐ slow heart rate (bradycardia)
- ☐ ☐ cold hands and feet
- ☐ ☐ rapid or irregular heatbeat (palpitations)
- ☐ ☐ rheumatic disorders if yes, what?
- ☐ ☐ fast heart rate (tachycardia)
- ☐ ☐ shortness of breath w/activity (dyspnea on exertion)
- ☐ ☐ hypertension (elevated blood pressure)

Respiratory

- ☐ ☐ cough
- ☐ ☐ shortness of breath
- ☐ ☐ sudden difficulty breathing while laying (paroxysmal nocturnal dyspnea)
- ☐ ☐ asthma inhaler? Y/N
- ☐ ☐ using ___extra pillows or sleeping upright (orthopnea)
- ☐ ☐ wheezing
- ☐ ☐ coughing up sputum
- ☐ ☐ difficult breathing unless sitting or standing (orthopnea)
- ☐ ☐ chronic bronchitis
- ☐ ☐ shortness of breath (dyspnea)
- ☐ ☐ bloody sputum/mucus (hemoptysis)
- ☐ ☐ pneumonia if yes, when?
- ☐ ☐ emphysema

Gastrointestinal

- ☐ ☐ nausea
- ☐ ☐ vomiting
- ☐ ☐ diarrhea
- ☐ ☐ abdominal pain
- ☐ ☐ indigestion
- ☐ ☐ recurrent acid reflux
- ☐ ☐ melena
- ☐ ☐ constipation
- ☐ ☐ bloody stools (hematochezia)
- ☐ ☐ bloody vomit (hematemesis)
- ☐ ☐ stomach problems
- ☐ ☐ heartburn
- ☐ ☐ bloating
- ☐ ☐ difficulty in swallowing (dysphagia)
- ☐ ☐ dry heaves
- ☐ ☐ change in bowel habits

Genitourinary

- ☐ ☐ blood I the urine(hematuria)
- ☐ ☐ frequency
- ☐ ☐ waking in the night to urinate (nocturia)
- ☐ ☐ abnormal bleeding
- ☐ ☐ vaginal itching or burning
- ☐ ☐ kidney stones if yes, when?
- ☐ ☐ urethral discharge
- ☐ ☐ sexually transmitted disease if yes, which type?
- ☐ ☐ urgency
- ☐ ☐ hesitancy
- ☐ ☐ incontinence
- ☐ ☐ painful intercourse
- ☐ ☐ pain during urination (dysuria)
- ☐ ☐ prostate problems
- ☐ ☐ excessive quantity of urine (polyuria)
- ☐ ☐ change in urinary habits
- ☐ ☐ swelling
- ☐ ☐ sexual difficulty
- ☐ ☐ burning
- ☐ ☐ no period
- ☐ ☐ irregular periods
- ☐ ☐ vaginal discharge
- ☐ ☐ vaginal odor
- ☐ ☐ swelling
- ☐ ☐ prostate problems

Injury Specialists Review of Systems

Endocrine

Y	N		Y	N		Y	N	
☐	☐	thyroid problems	☐	☐	excessive thirst (polydipsia)			
☐	☐	heat intolerance	☐	☐	cold intolerance	☐	☐	flushing
☐	☐	excessive thirst	☐	☐	excessive sweating	☐	☐	feeling of weakness
☐	☐	hair loss	☐	☐	dry skin	☐	☐	dry nails
☐	☐	diabetes Type I, Type II	—	—	Last A1C if diabetic?	—	—	

Musculoskeletal

Y	N		Y	N		Y	N	
☐	☐	joint stiffness	☐	☐	muscle cramps	☐	☐	back pain
☐	☐	joint swelling	☐	☐	pain in muscles (myalgias)	☐	☐	soft tissue swelling
☐	☐	arthralgias	☐	☐	muscle weakness	☐	☐	joint pain
☐	☐	paralysis	☐	☐	numbness	☐	☐	limb swelling

Neurological

Y	N		Y	N		Y	N	
☐	☐	tingling	☐	☐	memory lapses or loss	☐	☐	lightheadedness
☐	☐	syncope	☐	☐	confused or disoriented	☐	☐	facial weakness
☐	☐	vertigo	☐	☐	dizziness	☐	☐	numbness
☐	☐	convulsions	☐	☐	speech difficulties	☐	☐	weak limbs
☐	☐	poor coordination	☐	☐	burning sensation	☐	☐	seizures
☐	☐	tremors	☐	☐	bowel or bladder dysfunction	☐	☐	fainting

Psychologic

Y	N		Y	N		Y	N	
☐	☐	anxiety	☐	☐	depression	☐	☐	hypersensitivity
☐	☐	sleep disturbances	☐	☐	nervous			

Skin

☐	☐	rash	☐	☐	redness of the skin (erythema)	☐	☐	skin lesions
☐	☐	itching (pruritus)	☐	☐	paleness (pallor)	☐	☐	change in skin texture
☐	☐	blueness of the skin (cyanosis)	☐	☐	skin sore	☐	☐	yellowness of the skin (jaundice)
☐	☐	localized skin discoloration	☐	☐	skin bump, 0.5 cm or less	☐	☐	skin bump, more than 0.5 cm
☐	☐	lump						

Injury Specialists Review of Systems

Hematology/Immunology

Y	N		Y	N	
☐	☐	easy bleeding tendency	☐	☐	easy bruising tendency
☐	☐	HIV exposure	☐	☐	persistent infections
☐	☐	immune deficiency	☐	☐	strong allergic reactions
☐	☐	environmental allergies	☐	☐	other allergic/immunologic symptoms
☐	☐	history of blood clots if yes, taking blood thinner? Y/N	☐	☐	cancer if yes, which type?
☐	☐	frequent infections			chemotherapy Y/N radiation Y/N brachytherapy Y/N

Injury Specialists

Office Use_____

NP UP RT BIF RAF TZ

REGISTRATION FORM

(PLEASE PRINT)

Today's Date: _____ SS#: ___-___-____

Patients Name: _____ Birthdate: ___/___/____ Age: ____ Sex: M F

Street Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (___) ___-____ Cell Phone: (___) ___-____ Email Address: _____

Employer: _____ Occupation: _____ Work Phone: (___) ___-____

Employer Address: _____ City: _____ State: _____ Zip: _____

Marital Status: Single Married Widowed Separated Divorced Emergency Contact Name: _____

Relationship: _____ Phone: (___) ___-____ How did you hear about us? _____

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 vehicle 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: (___) ___-____ Address: _____

♦ HEALTH INSURANCE INFORMATION MUST BE COMPLETED ♦

PRIMARY INSURANCE INFORMATION

Name of Insurance Company: _____

ID: _____ Group: _____ Co-pay: _____

Subscriber's Name: _____ SS# ___-___-____ Date of Birth: ___/___/____

Relation to patient: _____ Employer: _____ Work Phone: _____

SECONDARY INSURANCE INFORMATION

Name of Insurance Company: _____

ID: _____ Group: _____ Co-pay: _____

Subscriber's Name: _____ SS# ___-___-____ Date of Birth: ___/___/____

Relation to patient: _____ Employer: _____ Work Phone: _____

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, and ApexNetwork Physical Therapy** 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, or if treated by **ApexNetwork Physical Therapy**, I will receive a separate bill for therapy services.*

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 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: ___/___/____

INJURY SPECIALISTS

CONSENT FOR TREATMENT

1. I,_____, hereby authorize Dr. Rachel Feinberg, Dr. Barry Feinberg and/or Dr Tong Zhu to perform the following procedure(s):

¨ Epidural Steroid Injections

¨ Trigger Point Injections

¨ Paravertebral / Facet Nerve / Medial Branch Blocks

¨ Joint Injections

¨ Stellate Ganglion Block

¨ Psoas Injections

¨ Other:

2. I consent to the performance of procedures in addition to or different from those now contemplated, whether or not arising from presently unforeseen conditions which the above named doctor, consider necessary or advisable in the course of the procedure.

3. I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for this service.

4. The nature and purpose of the procedure, possible alternative methods of treatment, the risks involved and the possible complications have been fully explained to me. No guarantee or assurance either orally or in writing has been given by anyone associated with Injury Specialists as to the result or outcome that may be obtained from the procedure undertaken.

I HAVE READ THIS CONSENT AND ITS CONTENTS HAVE BEEN FULLY EXPLAINED TO ME. I CERTIFY THAT I UNDERSTAND THE CONTENTS OF THIS CONSENT AND THAT I AM SIGNING IT VOLUNTARILY OF MY OWN ACT AND DEED BY CHECKING THIS BOX.

Patient Print Name	Patient Sign Name	Date

(consent valid for thirty days from date signature)

Patient is a minor or unable to sign, the responsible person may sign:

Patient Print Name	Gaurdian Print Name	Gaurdian Sign Name	Date

INJURY SPECIALISTS

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:

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 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 withdrawl 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.

_____	_____	_____
Patient Print Name	Patient Sign Name	Date

(consent valid for 365 days from date 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:

Risk factors of opioid use:

-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

All patients prescribed opioids that are equal to or greater than 50mg of the morphine equivalent dose will be prescribed naloxone.

_____	_____	_____
Patient Print Name	Patient Sign Name	Date

(consent valid for 365 days from date signature)

Name:_____ **Signature:**_____

Date:_____

(must be renewed every 3 months)

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	Sometimes	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?	O	O	O	O	O
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)	O	O	O	O	O
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)	O	O	O	O	O
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	O	O	O	O	O
5. In the past 30 days, how often have you seriously thought about hurting yourself?	O	O	O	O	O
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	O	O	O	O	O
7. In the past 30 days, how often have you been in an argument?	O	O	O	O	O
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	O	O	O	O	O
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	O	O	O	O	O
10. In the past 30 days, how often have you been worried about how you're handling your medications?	O	O	O	O	O

Double Sided 

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
11. In the past 30 days, how often have others been worried about how you're handling your medications?	O	O	O	O	O
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?	O	O	O	O	O
13. In the past 30 days, how often have you gotten angry with people?	O	O	O	O	O
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	O	O	O	O	O
15. In the past 30 days, how often have you borrowed pain medication from someone else?	O	O	O	O	O
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)?	O	O	O	O	O
17. In the past 30 days, how often have you had to visit the Emergency Room?	O	O	O	O	O

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.

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

 The SOAPP®-R was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PainEDU.org

Name_____ Signature_____

Date_____

	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?	o	o	o	o	o
14. How often have others told you that you had a bad temper?	o	o	o	o	o
15. How often have you felt consumed by the need to get pain medication?	o	o	o	o	o
16. How often have you run out of pain medication early?	o	o	o	o	o
17. How often have others kept you from getting what you deserve?	o	o	o	o	o
18. How often, in your lifetime, have you had legal problems or been arrested?	o	o	o	o	o
19. How often have you attended an AA or NA meeting?	o	o	o	o	o
20. How often have you been in an argument that was so out of control that someone got hurt?	o	o	o	o	o
21. How often have you been sexually abused?	o	o	o	o	o
22. How often have others suggested that you have a drug or alcohol problem?	o	o	o	o	o
23. How often have you had to borrow pain medications from your family or friends?	o	o	o	o	o
24. How often have you been treated for an alcohol or drug problem?	o	o	o	o	o

Please include any additional information you wish about the above answers.
Thank you.

PainEDU.org

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Financial Policies for Injury Specialists

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 policy is important to our practice. Please ask us if you have any questions about our fees, policy 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 can not be paid at the time of service, our office will assist you with re-scheduling 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 HMO's and PPO's 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 re-schedule your appointment when you have the necessary information needed for your visit.

- **As a courtesy to our patients**, this office will file insurance claims for professional services rendered. After the claim has processed and payment and/or an explanation of benefits has been sent, the patient will assume all responsibility for coinsurance, deductible, non-covered services and all un-paid services.

- Upon completion of your treatment, **ALL** unpaid balances, after insurance, must be paid within ninety (90) days. At this time, if no attempt has been made to settle your debt, then the account will be turned over to a collection agency and will be subjected to a 25% collection fee. A finance charge of 1.5% ($.50 minimum) will be applied to all balances over sixty (60) days old. Our annual percentage fee is 18%.

Work-Related Injuries

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

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

_____ _____

Signature of Patient Date

Revised 1/2013

Injury Specialists

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 sent to Injury Specialists for review) patient records.***

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

Persons/Organizations providing the information:

_____

_____

_____

Persons/Organizations receiving the information:

Injury Specialist
10435 Clayton Rd.
Suite 120
St. Louis, MO 63131
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 the extent the organization has taken action in reliance on the consent.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Date
(if patient is a minor)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Injury Specialists

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.

_____ _____

Patient/Guardian Signature Date

_____ _____

Witness Date

Gateway Pain Center, Inc.
dba Injury Specialists

10435 Clayton Road Ste 120
St Louis, MO 631312930
(314) 985-3002

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 to release medical information to my insurance carrier(s), managed care company(ies), Employee Assistance Programs(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 benefit/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. 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 to utilize electronic health records/electronic medical records (ie, medical record documentation, etc.) and electronic practice management functions (ie, 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 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. If my health plan utilizes pharmacy benefit management (PBM), I give consent to the above providers to release information to the PBM and its staff and receive information from the PBM and its staff for the purpose 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 to release health information by mail, phone, fax, or electronically to staff at laboratories and to receive information from staff at laboratories (ie., 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 Illinois Injury Specialists, Barry Feinberg MD, Rachel Feinberg MD to share necessary health information with staff they may hire to assist with billing, scheduling, or other office operations. I give consent to Injury Specialists, Barry Feinberg MD, Rachel Feinberg 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 in 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 Injury Specialists, Barry Feinberg MD, Rachel Feinberg 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 Illinois Injury Specialists, Barry Feinberg MD, Rachel Feinberg 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 exception 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 - 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.

_____ _____
Signature of Patient or Legal Guardian Date

Patient Name: DOB:

_____ _____
Signature of Witness Date

Injury Specialists

NOTICE OF PRIVACY PRACTICES OF INJURY SPECIALISTS

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.

Uses and Disclosure of Health Information:

Without your consent, we may use health information about your for treatment (such as sending your medical record information to a specialists physician as part of 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 of disclosing any 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 our 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 person listed below.

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 your. 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 against 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 (314) 895-3002 ext. 112

RECEIPT ACKNOWLEDGED: _____

Printed Patient Name: _____

Date: _____

Effective August, 2009 Revised: March 2012

Injury Specialists

Barry I. Feinberg, M. D. | Rachel A. Feinberg, M.D. | Tong Zhu, M.D.
314-985-3002 – 10435 Clayton Road – Suite 120 – Frontenac MO 63131-2931

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: _____

If you should decline to take these assessments, Injury Specialist will not be able to prescribe medications for you.

Injury Specialist
CESD-R Assessment

Name: _____ **Date:** _____

Below is a list of the ways you might have felt or behaved. Please check the boxes to tell us how often you have left 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
My appetite was poor.	0	1	2	3	4
I could not shake off the blues.	0	1	2	3	4
I had trouble keeping my mind on what I was doing.	0	1	2	3	4
I felt depressed.	0	1	2	3	4
My sleep was restless.	0	1	2	3	4
I felt sad.	0	1	2	3	4
I could not get going.	0	1	2	3	4
Nothing made me happy.	0	1	2	3	4
I felt like a bad person.	0	1	2	3	4
I lost interest in my usual activities.	0	1	2	3	4
I slept much more than usual.	0	1	2	3	4
I felt like I was moving too slowly.	0	1	2	3	4
I felt fidgety.	0	1	2	3	4
I wished I were dead.	0	1	2	3	4
I wanted to hurt myself.	0	1	2	3	4
I was tired all the time.	0	1	2	3	4
I did not like myself.	0	1	2	3	4
I lost a lot of weight without trying to.	0	1	2	3	4
I had a lot of trouble getting to sleep.	0	1	2	3	4
I could not focus on the important things.	0	1	2	3	4

Total Score: _____

Injury Specialist
PMQ-R Assessment

Name: _____ **Date:** _____

Answer the following questions by placing an "X" in the appropriate box.	**Never**	**Occasionally**	**Sometimes**	**Often**	**Always**
I believe that I am receiving enough medication to relieve my pain?					
My doctor spends enough time talking to me about my pain medication during appointments.					
I would feel better with a higher dosage of my pain medication.					
In the past, I have had some difficulty getting the medication I need from my doctor(s).					
I wouldn't mind quitting my current pain medication and trying a new one, if my doctor recommends it.					
I have clear preferences about the type of pain medication I need.					
Family members seem to think that I may be too dependent on my pain medication.					
It is important to me to try ways of managing my pain in addition to the medication (ex: relaxation, physical therapy, TENS unit, ect.)					
At times, I take my pain medication when I feel anxious and sad, or when I need help sleeping.					
At times, I drink alcohol to help control my pain.					
I find it necessary to go to the emergency room to get treatment for my pain.					
My pain medication makes me nauseated and constipated sometimes.					
At times, I need to borrow pain medication from friends or family to get relief.					
I get pain medication from more than one doctor in order to have enough medication for my pain.					
At times, I think I may be too dependent on my pain medications.					

	Never	Occasionally	Sometimes	Often	Always
To help me out, family members have obtained pain medication for me from their own doctors.					
At times, I need to take pain medication more often than it is prescribed in order to relieve my pain.					
I save my unused pain medication I have in case I need it later.					
I find it helpful to call my doctor or clinic to talk about how my pain medication is working.					
At times, I run out of pain medication early and have to call my doctor for refills.					
I find it useful to take medications (such as sedatives) to help my pain medication work better.					
	1	**2**	**3-4**	**4-5**	**5+**
How many painful conditions (injured body parts or illnesses) do you have?					
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?					
How many times in the past year have you run out of pain medication early and had to request an early refill?					
How many times in the past year have you accidentally misplaced your prescription for pain medication and had to ask for another?					

Total Score: _____