



ANA PAIN MANAGEMENT, P.C.

ANAND C. THAKUR
15945 19 Mile Road Ste 202
Clinton Township, Michigan 48038
Phone: 586-286-7246
Fax: 586-329-4751

OSWESTRY PAIN DISABILITY QUESTIONNAIRE

This questionnaire has been designed to give your Physician information as to how your pain has affected your ability to manage in everyday life. Please answer every section and mark only the ONE box which best applies to you at this moment.

SECTION 1 – PAIN INTENSITY

- I can tolerate the pain that I have without the use of medication.
- The pain is bad but I can manage without taking pain medication.
- Pain medication gives me complete relief from pain.
- Pain medication gives me moderate relief from pain.
- Pain medication gives me very little relief from pain.
- Pain medication has no effect on the pain and I don't use it.

SECTION 2 – PERSONAL CARE (Dressing)

- I can take care of myself normally without an increase in pain.
- I can look after myself normally but it increases in pain.
- It is painful to take care of myself, requiring me to be slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed. I wash myself with difficulty and stay in bed.

SECTION 3 – LIFTING

- I can lift heavy weights without increasing my pain.
- I can lift heavy weights but it does increase pain.
- Pain prevents me from lifting heavy weights off the floor, manageable if conveniently located.
- Pain prevents me from lifting heavy objects off the floor, but I can manage light to medium weights.
- I can lift only very light weights
- I cannot lift or carry anything at all

SECTION 4 – WALKING

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one mile.
- Pain prevents me from walking more than 1/2 a mile.
- Pain prevents me from walking more than 1/4 mile.
- I can only walk using a cane or crutches.
- I am in bed most of the time.

SECTION 5 – SITTING

- I can sit on any chair as long as I want.
- I can only sit in my favorite chair as long as I like
- Pain prevents me sitting more than one hour.
- Pain prevents me from sitting more than 30 minutes.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

SECTION 6- STANDING

- I can stand as long as I like without increasing my pain
- I can stand as long as I like but it increases my pain.
- Pain prevents me from standing for more than one hour.
- Pain prevents me from standing for more than 30 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

SECTION 7 – SLEEPING

- Pain does not prevent me from sleeping well.
- I can sleep well only using medication.
- Even with medication, I have less than 6 hours of sleep.
- Even with medication, I have less than 4 hours of sleep.
- Even with medication, I have less than 2 hours of sleep.
- Pain prevents me from sleeping at all.

SECTION 8 – SEX LIFE

- My sex life is normal and causes no increases in my pain.
- My sex life is normal but causes some increase in my pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by my pain.
- My sex life is nearly absent because of my pain.
- Pain prevents any sex life at all.

SECTION 9 – SOCIAL LIFE

- My social life is normal and does not increase my pain.
- My social life is normal but increases my pain.
- My pain has no effect on my social life apart from limiting my more energetic interests, such as dancing, etc.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of my pain.

SECTION 10 – TRAVELING

- I can travel anywhere without increasing my pain.
- I can travel anywhere but it increases my pain.
- My pain is bad but I manage trips over two hours.
- My pain restricts me to journeys of less than one hour.
- My pain restricts me to short, necessary trips under 30 minutes.
- My pain prevents me traveling except to my medical appointments or to the hospital

Patient Name: _____

Date: _____



Primary Pharmacy # _____
Emergency Pharmacy # _____

Agreement for Using Narcotics for Pain Control

1. I understand that using narcotics for non-cancer pain is currently controversial in both the public and medical communities.
2. I understand that the goal of using narcotics for pain is to decrease my pain and increase my functional level; therefore if my pain does not significantly decrease and my function significantly increases, the medications will be stopped.
3. I understand that using narcotics for a prolonged period of time may cause side effects including but not limited to lightheadedness, dizziness, nausea, constipation, fluid retention, swelling of the extremities, kidney and liver disease, depression, decrease in hormone levels, and physical dependence.
4. I understand the explanation that has been given to me about the difference between dependence and addiction.
5. I agree that I will inform the pain physician managing my narcotic maintenance program of **any and all changes** in my medical status including all changes in prescription and over the counter and herbal medications.
6. I understand it is my responsibility to inform my physician about any decrease in my ability to perform my daily activities.
7. I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until I can perform it safely.
8. I will not share, sell, or trade my medication for money, goods, or services.
9. I will not use any illegal controlled substances, including marijuana, cocaine, etc. I am aware that use may result in my discharge from ANA Pain Management.
10. I agree to use the medications **only as prescribed** by my Pain Physician.
11. **I agree that I will not seek out or use narcotics or other controlled substances from a source other than the Medical Staff of ANA Pain Management.**
12. I will not attempt to get pain medication from any other health care provider without telling them that I am taking pain medication prescribed by my Pain Physician. I understand that it is against the law to do so. If my Primary Care Physician is willing to prescribe my medications, the Pain Physician will have to approve the arrangements to avoid duplication. I agree to discontinue all previously used pain medications, unless I am told otherwise by my Pain Physician.
13. I understand that it is a felony to obtain pain medications under false pretenses.
14. **I understand that if I over use and run out of my medication it will result in my being without medication for a period of time and my medication will not be filled early.**
15. I understand that over use of my medication may cause death.
16. I agree to waive any applicable privilege or right of privacy of confidentiality with respect to other treating physicians, any city, state, or federal law enforcement agency including the Michigan Board of Pharmacy, my insurance company, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize the physician to provide a copy of this agreement to any of the above.
17. I understand that it is my responsibility to make all scheduled appointments and if I am greater than 15 minutes late that I may not be seen and must reschedule to obtain my pain medications.
18. I understand that I cannot obtain my medications by phone.
19. **I understand that routine blood work and random drug screens will take place as part of my treatment program.**

I have read the above agreement and understand the content in its entirety. In addition, all of my questions have been adequately answered.

Patient Signature

Date



ANA PAIN MANAGEMENT, P.C.

Patient Name: _____ **Date:** _____

- Are you **currently taking** any blood thinning medications such as **Aspirin, Coumadin, Plavix, Vitamin E, etc.?**

Yes

No

If you answered yes, please tell us which blood thinning medications you are currently taking:

- **Do you have a Pacemaker?**

Yes

No

- **Do you have a Defibrillator?**

Yes

No

Patient Signature: _____

(P) 586-286-7246 (pain) (F) 586-329-4751

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ANA PAIN MANAGEMENT, P.C.

Pharmacy Information

Patient Name: _____

Patient's Email: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy City: _____

Pharmacy State and Zip Code: _____

Pharmacy Phone Number: _____

Pharmacy Fax: _____

Prescription History Consent

I give my consent to have ANA Pain Management, P.C. to obtain my prescription history from external sources.

Date: _____

Patient or Authorized Person's Signature: _____

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Welcome!



Anand C. Thakur, MD
15945 19 Mile Road, Suite 202
Clinton Township, Michigan 48038
Phone: 586-286-7246 Fax: 586-329-4751

Thank you for choosing ANA Pain Management for your healthcare needs.

GETTING READY FOR YOUR VISIT

On your first visit, please bring any relevant medical records, X-rays, CT or MRI scans, medication bottles and other medical information related to the problem for which you are being seen.

Please complete the attached questionnaire **before** your appointment. It is confidential and will become part of your medical record. It asks for information about your current problems, and past medical history. This form will give your doctor a better understanding of your problem and will allow him to spend more time discussing treatment plans with you.

We value you as a patient and are providing the following information about clinic policies in order to assist us in delivering your healthcare needs.

It is **your responsibility** to obtain any HMO health insurance referrals that may be needed for your visit. This will include all the Medicaid and Blue Care Network plans. **If we do not receive your referral within 24 hours of the date of your appointment, we will need to reschedule your appointment. Co-Pays are your responsibility as dictated by most insurance policies and will be collected prior to seeing the physician.**

If you are being treated for a work or auto related injury, you must provide our office with written authorization from your employer or company handling your case. It should contain the following: authorization to be treated by our physician, name and address of the facility we are to bill to, claim number, date of injury, and adjuster name and phone number. If this is not received by your scheduled appointment date, we may need to reschedule you to another day and time.

CANCELLATION POLICY

We have established the following policies in order to provide every patient with care as quickly as possible, as we know your time is valuable.

Consult/New patient appointment: As a new patient, we will allow you to reschedule your consult appointment one time. After two cancellations and/or no-shows, you will not be allowed to reschedule with our office.

Existing Patients: Once you have become a patient of the office, we ask that you make your appointments carefully to ensure you are able to keep them. After three cancellations and/or no-shows you may be discharged from the office. This is based on Dr. Thakur reviewing your case.

There will be a \$50.00 charge or \$125 for procedure days, if notice is not received.

LATE POLICY

If you arrive past the indicated **"Arrival Time"** on your enclosed letter, you may be asked to reschedule. We ask that you arrive 10-15 minutes before your scheduled appointment time in order to allow time for registration.

If you arrive 15 minutes past your appointment time you may be asked to reschedule.

PRESCRIPTION DRUGS

Please be aware that we may **not** be able to provide you with medications. If you have been prescribed a medication by another physician, it is the responsibility of that physician to continue providing you with that medication unless otherwise stated by Dr. Thakur and he does chose to take over the care of your opioid pain medications.

We also ask that you bring all pill bottles for the medications you are currently taking to your visit. Dr. Thakur will determine the best possible treatment plan for you, but this may not include the continuation of current prescriptions.

PHYSICIAN PHONE CALLS

When calling the office to speak with Dr. Thakur or another member of the office we will do our best to return your phone call within 48 hours. Since we are not an Urgent care clinic, if you have an emergency we advise that you go to your nearest emergency room.

Sincerely,

Dr. Anand C. Thakur and Staff

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ANA PAIN MANAGEMENT, P.C.

Spouse / Parent Name _____

Relationship to patient? Spouse Parent Other _____

Street Address _____

City _____ State _____ Zip Code _____

Telephone Number _____

Nearest relative, not living with you? _____ Relationship? _____

Street Address _____

City _____ State _____ Zip Code _____

Telephone Number _____

Is this related to a motor vehicle accident? Yes No

Date of accident _____ Claim Number _____

Adjuster's Name _____ Phone _____

Address _____

Is the Claim still open? Yes No If so, Date Closed _____

Is this related to a worker's compensation accident? Yes No

Date of accident _____ Claim Number _____

Adjuster's Name _____ Phone _____

Address _____

Is the Claim still open? Yes No If so, Date Closed _____



ANA PAIN MANAGEMENT, P.C.

Primary Insurance Company Name _____

Street Address _____

City _____ State _____ Zip Code _____

Policy Type: Individual Cobra Group HMO PPO

ID Number _____

Group Number or Name _____

Policy Holder's Name _____
First Middle Last

Social Security Number _____ - _____ - _____ Birthday _____

Relationship to patient? Self Spouse Parent

Secondary Insurance Company Name _____

Street Address _____

City _____ State _____ Zip Code _____

Policy Type: Individual Cobra Group HMO PPO

ID Number _____

Group Number or Name _____

Policy Holder's Name _____
First Middle Last

Social Security Number _____ - _____ - _____

Relationship to patient? Self Spouse Parent

Patient Name (print)

Patient/Guardian Signature

Date

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ANA PAIN MANAGEMENT, P.C.

HIPAA AUTHORIZATION

For use or disclosure of health care information

By signing this form, I, _____, authorize ANA Pain Management the use and disclosure of my health information as described below:

You can disclose my health information as describe below:

- leave message on my answering machine
- leave message with spouse
- leave message with anyone who answers phone
- can fax information to my home
- can fax information to my work place
- can mail information to my home
- can mail information to my work place

You can leave message confirming appointments as described below:

- leave message on my answering machine
- leave message with spouse
- leave message with anyone who answers phone

Name of person/persons authorized to receive any information or pick up prescriptions/letters:

I understand that I have the right to revoke this authorization in writing at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do sin in writing and send it to:

ANA Pain Management
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Patient Name (print)

Patient Signature

Date

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ANA PAIN MANAGEMENT, P.C.

Assignment of Benefits

Assignment of Benefits

I hereby assign payment directly to accepting the assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for the charges not covered by my insurance company or for any and all charges which the insurance carrier declines to pay. It is further agreed that my credit balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician(s) by the insured or his/her family.

Release of Information

The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to the Health Care Financing Administration and/or the patient's attorney for all or part of the physician(s) charges including but not limited to patient insurance companies, worker's compensation carries, welfare funds or the patient's employer if it is a worker's compensation case.

Lifetime Authorization

Medicare and Medicaid Patient Certification-Payment Classification Authorization to Release Information and Payment Request: I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carries any information needed for this or a related Medicare, Medicaid, or other third party claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and co-insurance.

Please Note

Insurance contracts are made between you and the insurance company. We do not render service under the assumption that the charges will be pain by your insurance company. Payments of any and all charges are presumed to be your responsibility. All charges are due in full upon receipt of our state. A photocopy of this form shall be valid.

Date

Signature of Patient or Responsible Party

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ANA PAIN MANAGEMENT, P.C.

Financial Policies

Thank you for choosing ANA Pain Management. We are committed to the treatment of your condition. In order to provide your care, we require both treatment and financial compliance. Your clear understanding of our policies is important to our professional relationship.

If your insurance plan requires a copayment, it is payable at the time of service. If you present without a payment, we reserve the right to reschedule you or to bill you a \$10.00 administration fee.

We are happy to bill your primary insurance company directly if a copy of both sides of your insurance card is provided at the time of service, as well as all required demographic information necessary to file your claim. If you fail to provide the necessary demographic information to file your claim, you will be responsible for payment in full at the time of service. If payment is not received from your insurance company in ninety days, you will be expected to assist resolution of the open claim. If the claim continues to be unpaid after 120 days, we reserve the right to bill you directly. It is in your best interest to ensure that the correct insurance information is provided at the time of service.

If you have HMO coverage, it is your responsibility to obtain the necessary referral for your visit or procedure and forward a copy of this referral to our office prior to your visit or procedure. If you fail to do so, we reserve the right to reschedule your appointment.

Filing a secondary insurance is a courtesy to the patient and we will make one attempt to do so and then the balance will be your responsibility. If we receive payment from you and your secondary carrier, a refund of the overpayment will be made to you. We will not file tertiary insurance, but will provide a claim to you upon request. You are responsible for all tertiary balances.

All patients are expected to pay at the time of service. We accept cash, check, money order, Master Card, Visa American Express and Discover. Self-pay patients are required to pay in full at the time of service.

If for any reason a payment is dishonored by your bank, there will be a \$40.00 service fee added to your bill and you will be required to pay cash, certified check, money order or credit care for all future services.

We do accept Workers Compensation and Personal Injury cases. We will only file these claims with your regular insurance if a written denial from the workers compensation or personal injury carrier is received. We accept liens only for services provided in our office. All necessary legal contact information must be provided in advance of your service to allow us time to process the necessary lien paperwork.

We are participating providers for many plans. However, it is your responsibility to verify that the provider you are to see is in your network. If the provider is out of network and you see this physician, you are responsible for payment in full regardless of any insurance plan's arbitrary determination of usual and customary fees. There may be times when our physician is out of the office and you are required to see a physician who is not in your network. In these instances, we will work with your insurance plan to obtain in-network benefits and you will not be responsible for payment of the entire fee.

If you fail to meet your financial obligations in a timely manner, we reserve the right to discontinue care and refer your account to collections. You are responsible for any agency, attorney, interest, and other charges associated with collections.

Demographics

All patients are required to provide the necessary demographic information in order for us to provide care and bill for our services. You are required to notify us when any demographic information changes. You are required to provide a copy of your insurance card if your coverage changes. We reserve the right to change the required demographics in order to comply with legal or billing requirements.

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ANA PAIN MANAGEMENT, P.C.

Privacy

A copy of our complete privacy policy is provided to you at the time of your initial visit. This policy explains your rights including your right to see and copy your records, to limit disclosure of your protected health information and to request an amendment to your record. You may revoke in writing any consent for release of your health care information except to the extent the practice has already made disclosures with your prior consent.

Because of the privacy regulations we are not at liberty to discuss your treatment with anyone unless you specifically designate your permission to do so. If you wish to allow access to your protected health information to any individual, ask our receptionist for an Access to Medical Records form. By signing this release, you allow us to discuss your care with the specified individual(s). If a family member has concerns about your care, we may not discuss these concerns without your written permission.

Appointments

Please be sure to provide a telephone number where you may be reached. If you have voice mail on your contact telephone number, our staff will leave a message including the time, date and location of your appointment.

We require 24 hours' notice if you intend to cancel your appointment. Should you cancel, reschedule, or no-show for an appointment without 24 hour notice, we reserve the right to charge a \$50.00 no-show fee.

If you are scheduled for a procedure and cancel without 24 hour notice to our office, a cancellation fee of \$125.00 will be billed to you directly.

If you are more than 15 minutes late for your appointment, we reserve the right to reschedule your appointment or see you as the schedule permits. If you are a new patient and do not complete your forms in advance, you are required to be at the office at least 45 minutes in advance of your appointment to complete the necessary forms. Failure to do so will result in the rescheduling of your new patient visit.

Psychological Evaluation

Because of the nature of our treatment, there may be occasions when the physician determines that a psychological evaluation is necessary. For example, many healthcare plans require evaluations prior to intrathecal pump or spinal cord stimulator trials. **We reserve the right to discontinue care if you fail to obtain an evaluation as requested.**

Staff

We require our staff to address our patients with professionalism and we ask our patients to do the same. If at any time our staff feels that your tone or language is offensive or abusive, we expect them to terminate the conversation immediately and notify their immediate supervisor or practice administrator. **We will document your record and depending on the severity of the situation, you may be discharged from the practice.**

We are committed to providing the best treatment and ask your cooperation in following our policies.

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ANA PAIN MANAGEMENT, P.C.

I ACKNOWLEDGE RECEIPT OF A COPY OF THE PRACTICE'S FINANCIAL POLICIES.

I READ AND UNDERSTAND THE ABOVE POLICIES AND AGREE TO ABIDE BY THEM. I FURTHER UNDERSTAND THAT FAILURE TO DO SO MAY RESULT IN MY DISCHARGE FROM THE PRACTICE.

Patient Name (Print)

Patient Signature

Date

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ANA PAIN MANAGEMENT, P.C.

HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT of 1996

Notice of Privacy Practices

Effective: November 12, 2012

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

If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.

Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This Notice applies to all of the records of your care generated by your health care provider.

Our Responsibilities

ANA Pain Management, P.C. is required by law to maintain the privacy of your health information and to provide you with description of our legal duties and privacy practices regarding your health information. The current Notice will be posted in the waiting room. The notice will include the effective date. In addition, we will make our best effort to provide you with a copy of this notice and we request that you acknowledge receipt with your signature.

We are required by law to abide by the terms of this Notice and notify you if we make any changes to this Notice, which may be at any time. Changes to the Notice will apply to your medical information that we already maintain as well as new information received after the change occurs. If we change our Notice, it will be made available to anyone who asks for it, and be posted in the waiting room. You may also request that a revised Notice be sent to you in the mail or you may ask for one at your next appointment or appropriate visit. This Notice will also serve to advise you as to your rights with regard to your medical information.

How We May Use and Disclose Medical Information About You

The following categories describe examples of the way we use and disclose medical information.

For Treatment: We may use and disclose medical information about you to provide, coordinate and manage your treatment or services. We may disclose medication information about you to other doctors, nurses, technicians (e.g. clinical laboratories or imaging companies) medical students, or other personnel who are involved in your care. We may communicate your information either orally or in writing by mail or facsimile.

We may also provide subsequent healthcare provider with copies of various reports that should assist him or her in treating you. For example, your medical information may be provided to a physician to whom you have been referred so as to ensure that the physician has appropriate information regarding your previous treatment and diagnosis.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information before it approves or pays for the health care services we recommend for you.

For Health Care Operations: We may use or disclose, as needed, your health information in order to support our business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, legal advice, accounting support, information systems support and conducting or arranging for other business activities. In addition, we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment by telephone or reminder card.

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Notice of Privacy Practices Continued

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include collections and software support. If these services are contracted, we may disclose your health information to our business associate so that they can perform the job that we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information through written contract. In addition, business associates are individually required to abide by the HIPPA rules.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may also use and disclose your health information as set forth below. You have the opportunity to agree or object to the use or disclosure of all or part of your health information in these instances. If you are not present or able to agree or object to the use or disclosure of the health information (such as an emergency situation), then your clinician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

Individuals Involve in Your Care or Payment for Your Care: Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition status and location.

Future Communications: We may communicate to you via newsletters, mailings or other means regarding treatment options, information on health-related benefits or services; to remind you of your appointment for medical care; or other community based initiatives or activities in which our facility is participating. If you are not interested in receiving these materials please contact our Privacy Officer.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

As required by law: We may use and disclose health information to the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Authority that receives reports on abuse and neglect

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State-Specific Requirements: Many States have requirements for reporting, including population-based activities related to improving health or reducing health care costs.



Notice of Privacy Practices Continued

Your Health Information Rights

Although your health record is the physical property of the facility that compiled it, you have the right to:

Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. We ask that you submit these requests in writing. Usually, this includes medical and billing records, but does not include psychotherapy notes or information compiled in reasonable anticipation of or for use in a civil, criminal, or administrative action or proceeding. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. Requests for access to and copies of your medical information must be submitted to ANA Pain Management, P.C. in writing. The practice complies with state record release laws.

Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information by submitting a request in writing. You have the right to request an amendment for as long as we keep the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request an accounting of our disclosures of medical information about you except for certain circumstance, including disclosures for treatment, payment, health care operations or where you specifically authorized a disclosure. ANA Pain Management, P.C. will provide the first accounting to you in any 12-month period without charge. The cost for subsequent requests for an accounting within the 12-month period will be in accordance with the state records release laws. We ask that you submit these requests in writing.

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure that you had. We ask that you submit these requests in writing.

Except under specific circumstances, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment or is required by law. We must agree to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPPA) if the information pertains solely to a health care item or service for which we have been paid by you out-of-pocket, and in full.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternative address for billing purposes. We ask that you submit these requests in writing.

A paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To exercise any of your rights, please obtain the required forms from the Privacy Officer and submit your request in writing.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with use by calling (586) 286-7246 and asking for the Privacy Officer or by contacting the Secretary of the Federal Department of Health and Human Services. All complaints must be also submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided to you.

Privacy Officer: Dr. Anand C. Thakur

Telephone Number: (586) 286-7246

Prepared by Total Compliance Solutions, Inc. These procedures are prepared with the understanding that Total Compliance Solutions and its agents are not engaged in rendering legal, accounting or other professional services. This information is advisory only. Final interpretation is the responsibility of the regulatory or accrediting body administering the standard or regulation referenced.

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ANA PAIN MANAGEMENT, P.C.

Notice of Privacy Practices

I acknowledge having received a copy of the practice's Notice of Privacy Policies.

Patient Name (Print)

Patient Signature

Date

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ANA PAIN MANAGEMENT, P.C.

Patient's Name: _____

Date of birth: _____ Sex: M F

Daytime Phone: _____ Night Phone: _____

Name of Primary Care Physican: _____

Phone #: _____ Fax #: _____

List other physicians that your records should be sent to:

Doctor: _____ Doctor: _____

Phone #: _____ Phone #: _____

Fax #: _____ Fax #: _____

CAUSES OF YOUR PAIN: PLEASE ANSWER ALL QUESTIONS

Event(s) surrounding the onset of your pain

Date Pain Began

Pain intensity today

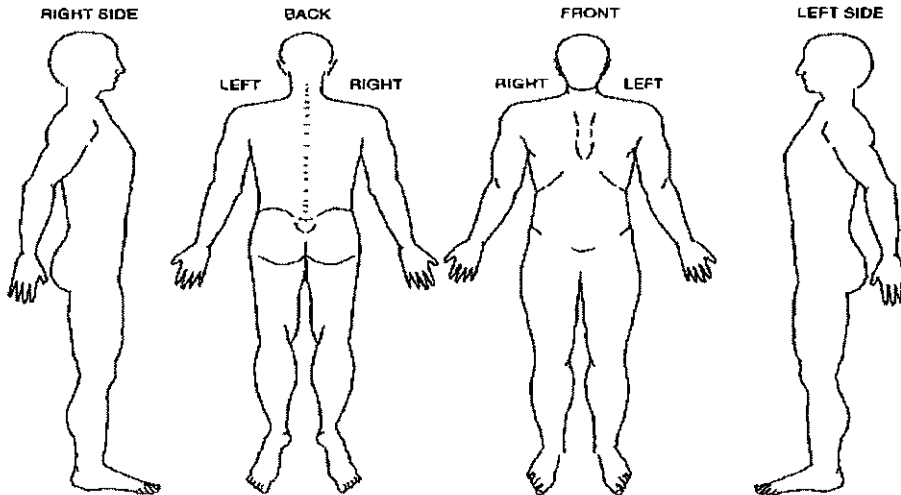
Better Same Worse
Better Same Worse
Better Same Worse
Better Same Worse

I believe my pain is due to (write description on line provided):

- The effects of treatment (medication, surgery, radiation, ect.) : _____
- My primary disease (meaning the disease currently being treated): _____
- A medical condition unrelated to my primary disease: _____
- Pain is related to a Motor Vehicle or work accident: _____

PAIN DESCRIPTION

On the Diagram, shade in the areas where you feel pain. Put on X on the area that hurts the most.



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ANA PAIN MANAGEMENT, P.C.

PAIN DESCRIPTION continued

Check all the things that make your pain **worse**:

- Sitting
- Standing
- Rest
- Heat
- Cold
- Walking
- Exercise
- Lifting
- Bending
- Other

Check all the things that make your pain **better**:

- Sitting
- Standing
- Rest
- Heat
- Cold
- Walking
- Exercise
- Lifting
- Bending
- Other

Please rate your pain by circling the one number that best describes your pain at its **worst in the last week**:

0 1 2 3 4 5 6 7 8 9 10

No pain

as bad as you can imagine

Please rate your pain by circling the one number that best describes your pain at its **best in the last week**:

0 1 2 3 4 5 6 7 8 9 10

No pain

as bad as you can imagine

Please rate your pain by circling the one number that best describes your pain **right now**:

0 1 2 3 4 5 6 7 8 9 10

No pain

as bad as you can imagine

For the following, check Yes or No if that word applies to your pain:

- | | | | |
|-----------|--|------------|--|
| Aching | <input type="checkbox"/> No <input type="checkbox"/> Yes | Burning | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Throbbing | <input type="checkbox"/> No <input type="checkbox"/> Yes | Exhausting | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Shooting | <input type="checkbox"/> No <input type="checkbox"/> Yes | Tiring | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Stabbing | <input type="checkbox"/> No <input type="checkbox"/> Yes | Nagging | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Gnawing | <input type="checkbox"/> No <input type="checkbox"/> Yes | Numb | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Sharp | <input type="checkbox"/> No <input type="checkbox"/> Yes | Miserable | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Tender | <input type="checkbox"/> No <input type="checkbox"/> Yes | Unbearable | <input type="checkbox"/> No <input type="checkbox"/> Yes |

Circle the one number that describes how, during the past week, pain has interfered with your:

General Activity:

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely Interferes

Mood:

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely Interferes



ANA PAIN MANAGEMENT, P.C.

PAIN DESCRIPTION continued

Concentration and thinking:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely Interferes	

Normal Work: (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely Interferes	

Relationships with other people:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely Interferes	

Sleep:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely Interferes	

Enjoyment of life:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely Interferes	

Appetite:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere									Completely Interferes	

PAIN TREATMENT(S)

How many physicians have been involved in the treatment of your pain?

- 0
 1-3
 4-5
 6-10
 11-15
 16 or more

If you have treated with another physician please let us know who and when.

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PAIN TREATMENT(S) continued

How many emergency room visits have you had in the past year for pain?

- 0 1-3 4-5 6-10 11-15 16 or more

If so where?

Check all other methods you use to relieve your pain:

- Warm Compresses Cold Compresses Relaxation techniques Distraction Medication Rest
- Other _____

In the last week, how much relief have pain treatments or medications provided? Please check the one that best represents how much relief you have received?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
No relief Complete relief

Check the nerve blocks, injections or procedures that have been performed. If you've had a procedure, but you don't remember what is was called, please choose "other".

	How Many	Date(s) Preformed
<input type="checkbox"/> Cervical (neck) epidural steroid injection	_____	_____
<input type="checkbox"/> Lumbar epidural steroid injection	_____	_____
<input type="checkbox"/> Caudal epidural steroid injection	_____	_____
<input type="checkbox"/> Lumbar Facet joint block	_____	_____
<input type="checkbox"/> Cervical Facet joint block	_____	_____
<input type="checkbox"/> Stellate ganglion block	_____	_____
<input type="checkbox"/> Lumbar sympathetic block	_____	_____
<input type="checkbox"/> Trigger point injection	_____	_____
<input type="checkbox"/> Discogram	_____	_____
<input type="checkbox"/> Occipital nerve block	_____	_____
<input type="checkbox"/> Spinal cord stimulator	_____	_____
<input type="checkbox"/> Intrathecal pump	_____	_____
<input type="checkbox"/> Other _____	_____	_____

Are you currently in Physical therapy? NO YES If yes are you getting relief? NO YES

If so where and how long? _____

PAIN MEDICATION

Do you have some form of pain now that requires medication every day? NO YES

Did you take pain medication in the last 7 days? NO YES

Do you feel you need to take more of the pain medication than your doctor has prescribed? NO YES

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PAIN MEDICATION continued

Check the box that pertains to you:

How do you prefer to take pain medication:

- On a regular basis
- Only when necessary
- Do not take pain medication

How do you take pain medication over a 24-hour period?

- Not every day
- 1-2 times a day
- 3-4 times a day
- 5-6 times a day
- More than 6 times per day

How long have you been on opioid pain medications?

- 0-1 year
- 1-2 years
- 3-4 years
- 5-6 years
- 6-7 years
- 8-9 years
- 10 + years

What % relief do your opioid pain medications provide?

- 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
- No relief Complete relief

Are your medications kept in a safe place? NO YES Where? _____

Do you feel you need to receive further information about your pain medications? NO YES

Past Pain Medications: Have you ever taken the following pain-related medications in the **PAST**? Do not list current medications on this page.

	NO	YES	Why did you stop?	
Acetaminophen (Tylenol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Amitriptyline (Elavil)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Baclofen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Belbuca	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Butrans patch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Capsaicin Cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Celebrex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Codeine (Tylenol #3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Cymbalta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Dilaudid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Fentanyl (Duragesic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Flexeril (Cyclobenzaprine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Hydrocodone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Ibuprofen (Motrin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working

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ANA PAIN MANAGEMENT, P.C.

PAIN MEDICATIONS CONTINUED

Past Pain Medications continued: Have you ever taken the following pain-related medications in the **PAST**?

Do not list current medications on this page.

	NO	YES	Why did you stop?	
Kadian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Lidoderm Patch or cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Lyrica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Methadone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Mobic (Meloxicam)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
MS Contin (Morphin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Neurontin (Gabapentin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Nucynta (Tapentadol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Opana (Oxymorphone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Percocet (Oxycodone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Oxaydo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Oxycontin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Robaxin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Skelaxin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Soma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Suboxone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Toradol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Ultram (Tramadol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Voltaren Gel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Zanaflex (Tizanidine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working
Xtampza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Side Effect(s) _____	<input type="checkbox"/> Didn't Work <input type="checkbox"/> Stopped working

Have you ever had an allergy or serious reaction to any food or medications including shellfish, Latex, or IVP Dye? Yes No **If yes, please describe:**

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ANA PAIN MANAGEMENT, P.C.

HOSPITALIZATION AND SURGICAL HISTORY

Please list with dates all surgeries or procedures you have had under anesthesia (including tooth extractions and tonsillectomy) as well as any problems with each:

Have you ever been hospitalized? Yes No If yes, explain:

REVIEW OF SYSTEMS

SELF			Family Member		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	When		<input type="checkbox"/> Yes <input type="checkbox"/> No	When
Heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No		Heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No		High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No		Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No		Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No		Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Epilepsy or seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No		Epilepsy or seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No		Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Chest pain on exertion	<input type="checkbox"/> Yes <input type="checkbox"/> No		<div style="border: 1px solid black; padding: 10px;"> <p>FEMALE PATIENTS ONLY:</p> <p>Do you think you are pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you use contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what type? _____</p> <p>Date of your last menstrual cycle: _____</p> </div>		
Chest pain at rest	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Bleeding Time	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Difficulty breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Abnormal chest x-ray	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Jaundice or hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Urine Retention	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No				

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PAST MEDICAL HISTORY

High blood pressure?	Yes	No	
Heart disease?	Yes	No	
Heart attack?	Yes	No	
CHF?	Yes	No	
Stroke?	Yes	No	
Chest Pain?	Yes	No	
High Cholesterol?	Yes	No	
Arrhythmia?	Yes	No	
Smoker?	Yes	No	
Asthma?	Yes	No	
COPD?	Yes	No	
Emphysema?	Yes	No	
Liver disease?	Yes	No	
Kidney disease?	Yes	No	
Ulcers?	Yes	No	
GERD?	Yes	No	
PUP?	Yes	No	
Diabetes?	Yes	No	If yes, what type? _____
Cancer?	Yes	No	If yes, what type? _____
Thyroid disease?	Yes	No	
Anxiety?	Yes	No	
Depression?	Yes	No	
Osteoarthritis?	Yes	No	
Rheumatoid arthritis?	Yes	No	
Bleeding disorders?	Yes	No	

Any other past or current medical history not noted above?



SOCIAL HISTORY

What is your involvement in social activities?

0 1 2 3 4 5 6 7 8 9 10

No involvement

Actively involved

Is this a change since the onset of your pain? NO YES

Do you currently smoke? NO YES If Yes: Packs per day _____ For how many years: _____

Where you a smoker in the past? NO YES If Yes: for how many years? _____ Year you Quit: _____

Do you use Alcohol? NO YES

If yes, on average, how many drinks do you have per week? 3 or less 4-7 8-12 13 or more

Was there ever a time in your life when you may have had an alcohol problem? NO YES

Did you ever, or do you now, use street drugs including Marijuana? NO YES

If yes, list _____

Have you ever been addicted to prescription drugs? NO YES

Does anybody in your family have a history of drug misuse/addiction? NO YES

Have you ever been in a treatment program for alcohol or drug abuse? NO YES

If YES explain: _____

What is your present marital status: Single Married Separated Divorced Widowed

Do you have children? NO YES If yes, how many? _____ How old? _____

Check the highest level of education completed.

Grade school High school GED Some college College graduate Trade school Bachelors Masters

WORK

Are you currently employed? NO YES

If yes: What do you do: _____ How many hours per day? _____

If no: How long have you been out of work? _____ What was your occupation? _____

How do you spend your day? _____

Is unemployment due to your pain? NO YES

Have you ever been in the military? NO YES

Are you able to do household chores? NO YES

List your Hobbies _____

Patient Signature: _____

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ASSESSMENTS

Head/Face

- Atypical Facial pain: G50.1
- Cervicogenic Headache/suboccipital Headache: R51
- Cluster headache: G44.009
- Occipital neuralgia/headache: M54.81
- Spinal headache: G97.1
- Temporomandibular Joint dysfunction: M26.60
- Tension Headache: G44.209
- Trigeminal neuralgia: G50.0

Cervical Spine

- Neck pain: M54.2
- High DDD: M50.31
- Mid DDD: M50.32
- C/T1 DDD: M50.33
- High Disc herniation: M50.21
- Mid Disc herniation: M50.22
- C7/T1 Disc herniation: M50.23
- Dystonia/Torticollis: M43.6
- Facet radiculopathy: M54.12
- Post-Laminectomy syndrome: M96.1
- Cervicothoracic Radiculopathy: M54.13
- Spinal Stenosis: M48.02
- Cervical Spondylosis: M47.812
- Sprain/Whiplash: S13.4xxA/D
- Cervical Strain: S16.1xxA/D

Thoracic Spine

- Thoracic pain: M54.6
- Compression fracture: M80.88
- Collapsed vertebrae: M48.54xA/D
- DDD: M51.34
- Disc herniation: M54.24
- DISH: M48.10
- Post-Laminectomy syndrome: M96.1
- Intercostal Neuropathy: G58.0
- Thoracic radiculopathy: M54.14
- Rib Sprain: S23.41xA/D
- Scoliosis: M41
- Spinal Stenosis: M48.04
- Thoracic spondylosis: M47.814
- Sprain of Ligaments: S23.3xxA/D

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- Thoracic outlet syndrome: G54.0

Lumbar Spine

- Ankylosing Spondylitis: M45.6
- Arachnoiditis (unspecified Meningitis): G03.9
- Bertolotti's syndrome: Q76.49
- Osteoporosis with fracture: M80.08
- Collapsed Vertebrae: M48.56xA/D
- DDD Lumbar: M51.36
- DDD L/S: M51.37
- Disc Herniation Lumbar: M51.26
- Disc Herniation L/S: M51.27
- Post- Laminectomy: M96.1
- Iliolumbar syndrome(sprain): S33.5xxA/D
- Low back pain: M54.5
- Lumbosacral plexopathy: G54.4
- Lumbar Radiculopathy: M54.16
- L/S Radiculopathy: M51.17
- Spinal Stenosis: M48.06
- 2/2 facet joint spurs and spondylolisthesis: M99.63
- 2/2 disc bulge and soft tissue: M99.73
- Spondylosis: M47.816
- Spasm of back muscle: M62.830
- Strain: S39.012

Sacrum/Buttock

- Cluneal Neuroma: M79.2
- Coccyx pain: M53.3
- Piriformis syndrome: LT G57.02 RT G57.01
- Sacroiliac joint disorder: M12.9
- Sacroiliac joint sprain: S33.6xA/D
- Sacroiliitis: M46.1
- Sacral and Sacrococcygeal spondylosis: M47.818

Pelvis/Hip/Thigh

- Arthritis of the hip: LT M25.752 RT: M25.751
- Bursitis Ischial or ischiogluteal: LT M70.72 RT: M70.71
- Bursitis Trochanteric: LT M70.62 RT M70.61
- Femoral Neuropathy: LT G57.22 RT G57.21
- Gluteal tendinitis: LT M76.02 RT M76.01
- Hamstring Strain: LT S76.312A RT S76.311A
- Iliotibial band syndrome: LT M76.32 RT M76.31
- Meralgia paresthetica: LT G57.12 RT G57.11
- Pain in hip: LT M25.552 RT M25.551

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□ Pain in leg: LT M79.605 RT M79.604

Knee

□ Arthritis: M17.0

□ Bursitis Prepatellar: LT M70.42 RT M70.41

□ Chondromalacia Patella: LT M22.42 RT M22.41

□ Knee pain: LT M25.562 RT M25.561

□ Patellar Tendinitis: LT M76.62 RT M76.61

□ Peroneal Neuropathy: LT S84.12xA/D RT S84.11xA/D

Other Lower Extremity

□ Complex pain syndrome Type 1: LT G90.522 RT G90.521 B/L G90.523

□ Complex pain syndrome Type 2: LT G57.72 RT G57.71 B/L G57.73

□ Phantom limb pain: G54.6

□ Restless leg syndrome: G25.81

Ankle/Foot

□ Achilles tendinitis/bursitis: LT M76.62 RT M76.61

□ Metatarsalgia: LT M77.42 RT M77.41

□ Morton's neuroma: LT G57.62 RT G57.61

□ Pain in ankle/foot: LT M25.572 RT M25.571

□ Plantar fasciitis: M72.2

□ Tarsal Tunnel syndrome: LT G57.52 RT G57.51

Shoulder

□ Frozen Shoulder: LT M75.02 RT M75.01

□ Bicipital tendinitis: LT M75.22 RT M75.21

□ Bursitis Subacromial: LT M75.52 RT M75.51

□ Bursitis Scapulothoracic: LT M75.82 RT M75.81

□ Labral Tear: LT S43.432A RT S43.431A

□ Osteoarthritis of shoulder: LT M25.712 RT M25.711

□ Pain in arm: LT M79.602 RT M79.601

□ Pain in shoulder: LT M25.512 RT M25.511

□ Paresthesia of skin: R20.2

□ Sprain of Sternoclavicular joint: S23.420A/D

□ Rotator cuff Strain: LT S46.012 RT S46.011

Elbow

□ Tennis elbow: LT M77.12 RT M77.11

□ Golfer's elbow: LT M77.02 RT M77.01

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□ Median Neuropathy (other than CTS): LT G56.12
RT G56.11

□ Olecranon Bursitis: LT M70.22 RT M70.21

□ Radial Neuropathy: LT G56.32 RT G56.31

Other Upper Extremity

□ Complex pain syndrome Type 1: LT G90.512 RT G90.511 B/L G90.513

□ Complex pain syndrome Type 2: LT G56.42 RT G56.41

Wrist/Hand

□ CTS: LT G56.02 RT G56.01

□ Ulnar Neuropathy: LT G56.22 RT G56.21

□ Radial styloid tenosynovitis: M65.4

□ Osteoarthritis of the wrist: LT M19.032 RT
M19.031

□ Osteoarthritis of the hand: LT M19.042 RT
M19.041

□ Trigger finger: M65.30

□ Wrist drop: LT M21.332 RT M21.331

Miscellaneous

□ Chronic pain Syndrome: G89.4

□ Opioid induced constipation: K59.09

□ Costochondritis: M94.0

□ Edema: R60.1

□ Fibromyalgia: M79.7

□ Gait abnormality: R26.81

□ Long term Opioid usage: Z79.891

□ MS: G35

□ Myalgia: M79.1

□ Muscle weakness: M62.81

□ Obesity (overweight): E66.3

□ Obesity (morbid obesity): E66.01

□ Post herpetic neuralgia: B02.29

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