GLOWACKI MD
INSTITUTE FOR PAIN, SPINE & HEADACHE DISORDERS

Dear patient,

Thank you for choosing GlowackiMD Enclosed are attached forms we ask that you bring to your upcoming appointment. Please complete all forms entirely prior to arriving.

You will need to arrive **at least 30 minutes prior** to your scheduled appointment time.

THE FOLLOWING IS A LIST OF REQUIRED MATERIALS FOR YOUR UPCOMING APPT:

Driver's license or state I.D.

Insurance card

Up to date medication list

All medical records pertaining to your pain or diagnosis, including but not limited to, imaging reports and discs (i.e. MRI, CT Scan, X-Ray, etc.), office notes, or any other records you may have

NOTE: If you have been treated by another pain physician or facility and/or received any pain procedures in the past, you must provide our office with a copy of those records. This is required in effort to avoid potential billing complications.

If you are currently on any prescription blood thinners, please be sure to notify our office prior to the date of your upcoming appointment. You will need to provide our staff with the name and phone number of your managing physician in order to obtain clearance for potential procedures.

Please contact our office at (248) 813-0060 with any questions. We look forward to seeing you.

Thank you,

GlowackiMD staff

GLOWACKI MD
INSTITUTE FOR PAIN, SPINE & HEADACHE DISORDERS

NEW PATIENT INFORMATION RECORD

- PATIENT INFORMATION -

Last Name ______________________ First _________________ Middle_____ Preferred _________________

Date of Birth ________________ Sex ____ Age ______ Race ___________ Martial Status ______________

Address ____ City _______________ State_____ Zip _________

Home # (   ) _________________ Mobile # (   ) __________________ Work # (   ) _______________

SS# _________________ Primary E-mail Address _________________________________

- EMERGENCY CONTACT / NEAREST RELATIVE NOT LIVING AT HOME -

Name ____________________________ Relationship _______________ Phone # (   ) _________________

- PREFERRED PHARMACY -

Name of pharmacy ____________________________________ Phone # (   ) _________________

Address ____ City _______________ State_____ Zip _________

- REFERRING PHYSICIAN -

Name ____ Phone # (   ) _________________

Address _____________________________ Suite # ____ City _______________ State_____ Zip _________

- PRIMARY CARE PHYSICIAN -

Name ____ Phone # (   ) _________________

Address _____________________________ Suite # ____ City ______________ State _____ Zip _________

- EMPLOYER INFORMATION -

[ ] Currently employed [ ] Unemployed [ ] Retired [ ] Legally disabled

Company Name __________________________ Address ____

City ______________________________ State _______ Zip _____ Work Phone (   ) _______________

If married, please list spouse's employment information

Employer ____ Phone # (   ) _________________

Address ________________________________ City _______________ State ____ Zip _________

GLOWACKI MD INSTITUTE FOR PAIN, SPINE & HEADACHE DISORDERS

INSURANCE INFORMATION

- PRIMARY CARDHOLDER INFORMATION (If different from patient) -

Name ______________________________ DOB______________ SS# ____________________

Address ____________________________ City ____________________ State ____ Zip ________

Home # (   ) ____________ Work # (   ) ______________ Relationship ____________________

- SECONDARY CARDHOLDER INFORMATION (If different from patient) -

Name ______________________________ DOB______________ SS# ____________________

Address ____________________________ City ____________________ State ____ Zip ________

Home # (   ) ____________ Work # (   ) ______________ Relationship ____________________

- WORKER'S COMPENSATION INFORMATION -

Date of Injury ____________ Claim # ______________ Ins. Carrier ____________________

Address ______________________________ City ________________ State ___ Zip ______

Telephone # (   ) ______________ Adjuster ____

Employer at time of injury __________________ Description of accident ____________________

Employer's address at time of injury ____

Treating MD ____________________ Address __________________________________

City ____________________ State _______ Zip _______ Telephone # (   ) ______________

Circle One

Y   N   INSURANCE AUTHORIZATION

I hereby authorize GlowackiMD to furnish information to my insurance carriers concerning my illness and treatment.

Y   N   ASSIGNMENT OF BENEFITS

I hereby assign to GlowackiMD all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

Y   N   TREATMENT AUTHORIZATION

I hereby authorize GlowackiMD to render health care to me during my visit.

Y   N   PRIVACY NOTICE

I have received a Notice from GlowackiMD that explains how my personal health information will be used.

GLOWACKI MD
INSTITUTE FOR PAIN, SPINE & HEADACHE DISORDERS

COMPREHENSIVE PAIN QUESTIONNAIRE

Complete this form before your first appointment at GlowackiMD Your careful answers will help us to understand your pain problem and design the best treatment program for you. You may feel concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential. No outsider is permitted to see your case record without your written permission unless we are required to do so by law (e.g., Workman's Compensation Claims, etc.).

Name: ________________________________ **Referred by:** ________________________
(Last, First, Middle)

CHARACTERISTICS OF PAIN

What is the main problem for which you are seeking treatment at GlowackiMD?
(What type of pain? Back, neck, leg, joint, etc.):

____

____

____

PAIN INTENSITY

Please circle your current level of pain.

0 1 2 3 4 5 6 7 8 9 10
least most

PAIN DURATION

How long have you had your current pain problem (in years and/or months)?
_____ (#) years _____(#) months

ONSET OF PAIN

How did your current pain start?
[ ] Injury at work
[ ] Injury, not at work
[ ] Treatment caused (e.g., radiation, surgery, etc.)
[ ] Motor vehicle accident
[ ] Unknown

Please explain

____

____

____

PROGRESSION OF PAIN

[ ] Gradual onset
[ ] Rapid onset

GLOWACKI MD INSTITUTE FOR PAIN, SPINE & HEADACHE DISORDERS

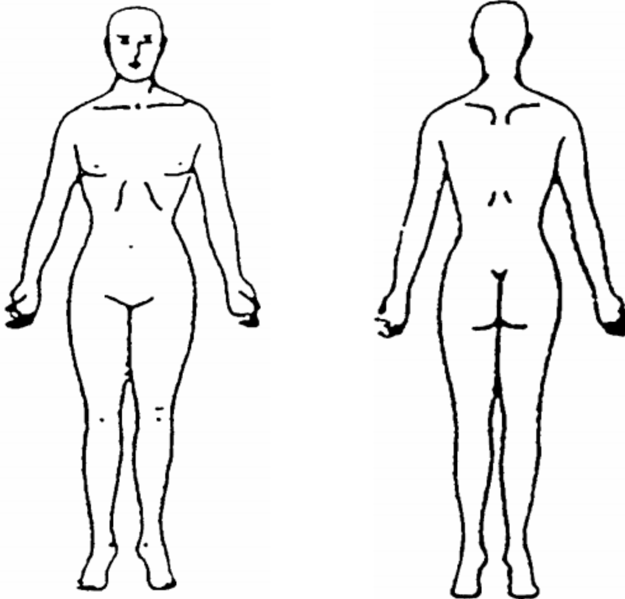
PAIN QUALITY

How would you describe the pain? (Please check all that apply).

[ ] burning	[ ] sharp	[ ] cutting	[ ] throbbing
[ ] cramping	[ ] numbness	[ ] dull, aching	[ ] pressure
[ ] pins and needles	[ ] shooting	[ ] other________________________	

PAIN LOCATION

Please indicate the location(s) of your pain:



Please mark the location(s) of your pain on the diagrams to the left with an "X."

If whole areas are painful, please shade in the painful area.

SLEEP DISTURBANCES

Do you have difficulty falling asleep?	[ ] Yes	[ ] No	Comments: ________________________
Do you have difficulty remaining asleep?	[ ] Yes	[ ] No	Comments: ________________________
Are you ever awakened by the pain?	[ ] Yes	[ ] No	Comments: ________________________

RELIEVING AND AGGREVATING FACTORS

How do the following affect your pain? (Please check one box for each item)

	Decrease	Increase	No Change
Lying down	[ ]	[ ]	[ ]
Standing	[ ]	[ ]	[ ]
Sitting	[ ]	[ ]	[ ]
Walking	[ ]	[ ]	[ ]
Exercise	[ ]	[ ]	[ ]
Medications	[ ]	[ ]	[ ]
Relaxation	[ ]	[ ]	[ ]
Thinking about something else	[ ]	[ ]	[ ]
Coughing/Sneezing	[ ]	[ ]	[ ]
Urination	[ ]	[ ]	[ ]
Bowel movements	[ ]	[ ]	[ ]

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INSTITUTE FOR PAIN, SPINE & HEADACHE DISORDERS

PAIN TREATMENTS

Please check all of the treatments you have tried for your pain and complete the appropriate column at the right.

Treatment	Date (approx)	No Relief	Moderate Relief	Excellent Relief
[ ] Hospital bed rest	________	[ ]	[ ]	[ ]
[ ] Traction	________	[ ]	[ ]	[ ]
[ ] Surgery	________	[ ]	[ ]	[ ]
[ ] Hypnosis	________	[ ]	[ ]	[ ]
[ ] Acupuncture	________	[ ]	[ ]	[ ]
[ ] Nerve block or other injections	________	[ ]	[ ]	[ ]
[ ] TENS	________	[ ]	[ ]	[ ]
[ ] Physical therapy	________	[ ]	[ ]	[ ]
[ ] Exercise	________	[ ]	[ ]	[ ]
[ ] Heat treatment	________	[ ]	[ ]	[ ]
[ ] Ice treatment	________	[ ]	[ ]	[ ]
[ ] Psychotherapy	________	[ ]	[ ]	[ ]
[ ] Chiropractic	________	[ ]	[ ]	[ ]
[ ] Other	________	[ ]	[ ]	[ ]

REVIEW OF SYSTEMS

Please check all items you feel are applicable to you.

[ ] Do you have ringing in ears, hearing loss, or ear pain?
[ ] Double or blurred vision?
[ ] Do you have shortness of breath?
[ ] Do you have palpitations (awareness of fast heart)?
[ ] Do you have chest pain?
[ ] Abdominal pain or nausea?
[ ] Vomiting spells? (other than during pregnancy)
[ ] Intolerance of a variety of foods?
[ ] Diarrhea?
[ ] Urinary retention or difficulty urinating?
[ ] Urinary frequency or incontinence?
[ ] Do you have genital pain (other than during sex)?
[ ] Do you experience pain during intercourse?
[ ] Do you have back pain or stiffness?
[ ] Do you have joint swelling?
[ ] Headaches?
[ ] Seizures or convulsions?
[ ] Tremors?
[ ] Difficulty swallowing, sore throat?
[ ] Problems with excessive bleeding or bruising?
[ ] Muscle weakness?
[ ] Recent unexplained weight loss, fatigue, fever?
[ ] Do you frequently have dizziness?
[ ] Fainting spells, loss of consciousness, or blackouts?
[ ] Blindness, pain in eyes, excessive tearing?
[ ] Do you have neck pain or stiffness?
[ ] Do you have pain in the arms and/or legs?
[ ] Do you have joint pain (knee, elbow, etc.)?

PRIOR MEDICAL HISTORY

Have you had any of the following health problems? (Please check all that apply).

[ ] AIDS/HIV
[ ] Acid Reflux (GERD)
[ ] Anemia
[ ] Anxiety Disorder
[ ] Arthritis
[ ] Asthma
[ ] Back Injury
[ ] Bleeding Disorder
[ ] COPD
[ ] Chronic Ear Infections
[ ] Coronary Artery Disease
[ ] Depression
[ ] Diabetes / high blood sugar
[ ] Difficulty Swallowing
[ ] Fibromyalgia
[ ] Gout
[ ] Head Trauma/Injury
[ ] Headaches
[ ] Heart Attack (MI)
[ ] Heart Disease
[ ] Hepatitis
[ ] Hernia
[ ] High Cholesterol
[ ] Hypertension
[ ] Kidney Disease
[ ] Liver Disease
[ ] Osteoporosis
[ ] TIA or Stroke
[ ] Substance Abuse
[ ] Thyroid Problems
[ ] Tuberculosis
[ ] Ulcers
[ ] Cancer (please specify): ____________________
[ ] Other (please specify): ____________________

SURGERIES

Date (approx)	Hospital or Facility	Type of Operation

HAVE YOU EVER BEEN SEEN AT ANOTHER PAIN FACILITY OR UNDERGONE ANY PROCEDURES?

If yes, please indicate the following:

Date (approx)	Doctors Name	Facility Name	Type of Treatment/Procedure

MEDICATIONS (can attach list)

Indicate the prescription medications you are currently taking. Please tell us the dosage of your pain medications (if known) and the number of pills you take (on average) of this medication.

* PAIN Medication(s)	Dosage/Amount	* OTHER Medication(s)
____________	____ / ____	____________
____________	____ / ____	____________
____________	____ / ____	____________
____________	____ / ____	____________

Indicate any other pain medications you have previously tried.

____

____

____

Indicate any blood thinners you are on.

____

____

____

ALLERGIES

Please indicate the names of any medications to which you are allergic.

____
____
____

[ ] Yes, I am allergic to dye put into my body (X-ray dye)

HEIGHT & WEIGHT

Please indicate your height and weight: ______ ' ______" ________ lbs

HEIGHT WEIGHT

LEGAL ISSUES

Please indicate any of the following claims you have filed related to your pain problem:

[ ] Workers' compensation
[ ] Motor Vehicle Accident
[ ] Personal injury/liability (unrelated to work)
[ ] Social Security Disability Insurance (SSDI)

** **NOTE**: If you have a worker's compensation or motor vehicle accident claim, you must notify our office.

PSYCHOLOGICAL TREATMENT

Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain? [ ] Yes [ ] No If yes, when? ______________________________

Have you ever considered suicide? [ ] Yes [ ] No

SOCIAL HISTORY

Do you smoke? [ ] Yes [ ] No If yes, how much? ____________________

Vaporizers or e-cigarettes? [ ] Yes [ ] No If yes, how much? ____________________

Do you drink any alcohol? [ ] Yes [ ] No If yes, how often? ____________________

Do you have any history of substance abuse? [ ] Yes [ ] No

If yes, which kind? ______________________________

Do you have any history of prescription medication abuse? [ ] Yes [ ] No

If yes, please explain: ______________________________

FAMILY HISTORY

Family history of back pain? [ ] Yes [ ] No If yes, whom? ____________________

Family history of migraine headaches? [ ] Yes [ ] No If yes, whom? ____________________

Family history of any other medical problems (high blood pressure, diabetes, heart disease, cancer, etc.)?

[ ] Yes [ ] No If yes, please specify which family member and condition: ____________

____
____
____

GLOWACKI MD
INSTITUTE FOR PAIN, SPINE & HEADACHE DISORDERS

Patient Name: ______________________________

OSWESTRY DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

(NECK PAIN)

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which MOST CLOSELY describes your problem.

Section 1 – Pain Intensity
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.)
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am 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 with difficulty and stay in bed.

Section 3 – Reading
- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain.
- ☐ I can't read as much as I want because of pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 4 – Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have slight headaches which come frequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Section 5 – Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 6 – Concentration
- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7 – Work
- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

Section 8 – Driving
- ☐ I drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 – Sleeping
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation
- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability. (Score ___ x 2) / (___ Sections x 10) = ___________ %ADL

GLOWACKI MD
INSTITUTE FOR PAIN, SPINE & HEADACHE DISORDERS

Patient Name: ______________________________

OSWESTRY DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

(BACK PAIN)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which MOST CLOSELY describes your problem.

Section 1 – Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

Section 2 – Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am 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 with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e., on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift 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 one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from 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 almost all the time.

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing 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 by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ 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 pain.

Section 9 – Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability. (Score ___ x 2) / (___ Sections x 10) = ___________ %ADL

GLOWACKI MD
INSTITUTE FOR PAIN, SPINE & HEADACHE DISORDERS

HIPAA PRIVACY AUTHORIZATION

PATIENT NAME: ____ **DATE OF BIRTH:** ____________

I, ____________________________ hereby authorize GlowackiMD to disclose my protected health information (PHI) to the following individuals:

1. ____ Relationship: _______________ Phone: ______________
2. ____ Relationship: _______________ Phone: ______________
3. ____ Relationship: _______________ Phone: ______________

I request the following restriction(s) to releasing my PHI:

____

____

The type and amount of information to be used or disclosed is the entire medical chart, including medical records, center notes, hospital records, pharmaceutical records, laboratory records, x-ray and MRI films, CAT scans, any other radiological films, and medical bills.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the person or entity I authorized to release my information. I understand the revocation will not apply to information that has been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall be in full force and effect until such time as the medical provider no longer maintains the health insurance.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

A photocopy of this authorization shall be considered as effective and valid as the original.

Patient Signature: ____ **Date:** ________________

Witness Signature: ____ **Date:** ________________

GLOWACKI MD INSTITUTE FOR PAIN, SPINE & HEADACHE DISORDERS

Patient Administrative Acknowledgement Form

Financial Responsibility: I understand that as a courtesy, GlowackiMD will file medical claims on my behalf to the insurance carrier(s) I have coverage with per the insurance information provided by me at the time services are rendered. In some cases, exact insurance benefits cannot be determined until the insurance carrier receives the claim. I am responsible for the entire bill or balance of the bill as determined by GlowackiMD if the submitted claim(s) or any part of them is denied for payment. I understand that it is my responsibility to notify GlowackiMD of any changes in my health care coverage and benefits. I understand that my particular coverage is a contract between my health insurance plan(s) and myself. I understand that by signing this form, I am accepting financial responsibility for the total payment of all medical services received. Upon receiving a statement from GlowackiMD, I agree to pay the balance in full within 30 days following the statement date. Failure to remit payment within the given time frame can result in late fee assessments and possible collections by an outside agency.

Assignment of Benefits: I authorize direct remittance of payment of all insurance benefits to GlowackiMD for all covered medical services provided and supplies to me during all courses of treatment and care from GlowackiMD I acknowledge that my insurance carrier(s) may issue a check for services provided by GlowackiMD directly to me or the subscriber of the policy, and in this event, I will take responsibility of paying GlowackiMD directly. Failure to remit payments within the given time frame can result in collection efforts by GlowackiMD, as well as outside collection agencies.

Authorization to Release Information: I authorize the release of any pertinent medical or other information to my insurance carrier(s), or any other entity necessary to determine my insurance benefits payable for related medical services provided to me by GlowackiMD A copy of this authorization may be sent to the above-mentioned parties, if requested.

Cancellation Policy: Same day cancellation, or no call/no shows, may result in a $25 charge for all office visits, including evaluations, re-evaluations, consultations, etc. and a $50 charge for procedure appointments. Charges will be added to account at the discretion of office management.

Receipt of HIPAA Notice: I, by my signature, acknowledge that I have been offered and received the Notice of Privacy Practices for GlowackiMD I understand that upon request I may receive another copy of the notice.

Medication History Authority: By signing below I give my permission for GlowackiMD and all other assistants, affiliates, and associates to access my pharmacy benefits data electronically and non-electronically. This consent will enable GlowackiMD to determine the pharmacy benefits and drug co-payments for a patient's health plan, check whether a prescribed medication is covered (in formulary) under a patient's plan, determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies if allowed, download a historic list of all medications prescribed to me and/or filled by me by any provider. In summary, we ask your permission to obtain formulary information, and information about any/all prescriptions prescribed by any/all providers.

______________________	______________________	__________
Patient Signature	**Patient Name (Printed)**	**Date**

______________________	__________
Witness Signature	**Date**

GLOWACKI MD
INSTITUTE FOR PAIN, SPINE & HEADACHE DISORDERS

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2** for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3** for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4** for more information on these uses and disclosures*

GLOWACKI MD INSTITUTE FOR PAIN, SPINE & HEADACHE DISORDERS

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

SERVICES

Our purpose at GlowackiMD is to utilize a multidisciplinary approach combining interventional procedures, medical management, alternative medicine, physical therapy and surgical inputs to reduce or eliminate your pain and to restore your ability to live and work as you desire.

Many physicians continue to treat patients with medication or surgery before the specific cause of their pain has been identified. This dramatically increases the risk of complications and often results in poor outcome. The specialty of Interventional Pain Management has been developed to address this urgent need for more accurate diagnosis and treatment of painful conditions.

During your initial visit to GlowackiMD, your physician conducts a complete pain history and focused physical examination. All pertinent medical history and diagnostic studies are carefully reviewed. Additional testing or diagnostic injections may be recommended to determine the specific origin of your pain prior to the initiation of therapy. Your physician will custom tailor an individual pain management program. This will be discussed with you and a full report is sent to your referring doctor.

At GlowackiMD, we treat your pain by reducing the inflammation or desensitizing the painful nerves, spinal discs, joints or muscles responsible for your symptoms. We specialize in treating a variety of painful conditions including low back pain, neck pain, RSD, shingles pain, neuropathy, cancer pain, headache, joint pain and musculoskeletal pain. Our physicians are renowned for treating headaches and neck pain in patients who have failed most other therapies.

During their extensive fellowship training, Dr. Glowacki and Dr. Conroy perfected advanced pain procedures such as neurostimulators, pain pumps, nucleoplasty, micro-invasive disc procedures, as well as, more common procedures including epidural steroid injections, nerve blocks, and radiofrequency ablation. Our use of fluoroscopy (real-time x-ray) to perform the diagnostic and therapeutic injections allows us to maximize accuracy and avoid side effects.

All of our procedures are performed on an outpatient basis in a relaxed and healing spa-like environment. Our facilities are staffed by specially trained personnel and equipped with the most sophisticated technology. At GlowackiMD, we believe that our compassionate and expert care will provide you with a beneficial and rewarding experience so that you may finally wake up to a pain free day.

OFFICE POLICIES

Insurance Policy: We accept new patients with or without a physician referral unless your insurance requires a referral. We accept Medicare, BCBS, BCN, Cigna, HAP, Medicare Combo Plans, Priority Health, and most all commercial insurances.

Workers Comp, and Auto Insurance: We also accept workers comp and auto insurance on a case-by-case basis. Please have a letter from your case manager stating that you have an "open and billable claim" at the time of your visit. It will be necessary for you to be seen.

Appointment Cancellation Policy: Any appointment cancellation not made with at least a 24-hour notice is subject to a $25.00 fee for routine office visits and a $50.00 fee for procedure appointments. Scheduling is done in accordance with patient's insurance guidelines.

New Consults: Please arrive 30 minutes prior to scheduled appointment to fill out necessary paperwork.

Procedures: No eating or drinking 6 hours prior to procedure and a driver must accompany you.

** **ALL HIPPA GUIDELINES AND PATIENT PRIVACY RIGHTS ARE FOLLOWED WITH NO EXCEPTIONS** **

GlowackiMD
6535 Rochester Road, Suite 102 Troy, MI 48085
Phone: (248) 813-0060 **Fax**: (248) 813-0066

GLOWACKI MD INSTITUTE FOR PAIN, SPINE & HEADACHE DISORDERS

FINANCIAL POLICY

GlowackiMD believes that part of good health care practice is to establish and communicate our financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to understand our financial policy and seek answers to any questions that you may have.

1. PAYMENT is expected at the time of service. We accept cash, check, money orders, and credit cards, with the exception of American Express and Discover. Payments expected will be for unmet deductible, co-insurance, co-payment amounts, and/or non-covered charges from your insurance company. **2. INSURANCE:** We participate with several insurance plans. We will file all insurance claims for you. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. It is the responsibility of the patient to know their coverage and benefits. If your insurance company deems any Field Services should be a non-covered benefit, you, the patient, are responsible. If you have an HMO plan, you are also responsible for referrals and global referrals. **3. RETURNED CHECKS** will incur a $35 service charge. Once we receive a returned check on your account, we will no longer accept payment by way of check. Stop payment constitutes a breach of payment and will incur a $35 charge, also. **4. FORM FEES:** Our office underline does not complete disability assessment paperwork or functional capacity assessments. We will provide medical records as requested with signed consent from the patient. For printed copies of your medical records, there will be a $25 charge and if the records are greater than 25 pages or more, the fee will be $40. **5. BILLING QUESTIONS** can be directed to the practice manager, Nikki Potts at (248) 813-0060. **6. CANCELLATIONS OR MISSED APPOINTMENTS:** If you do not give a 24-hour notice of cancellation for re-evaluation or medication refill appointments, there will be a $25 fee assessed to your account. If you do not give a 24-hour notice of cancellation for a procedure, a fee of $50 will be assessed to your account. If you have payment arrangements or a financial hardship agreement in place and you do not give cancellation notice, the plan of assistance will be removed, and you will be responsible for payment in full. **7. RESPONSIBILITY FOR PAYMENT:** I understand that I am, personally, and financially responsible to GlowackiMD for all charge not covered by the assignment of insurance benefits. **8. ASSIGNMENT OF INSURANCE BENEFITS:** I hereby, assign, transfer, and set over directly to GlowackiMD sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the cost of the care and treatment rendered to myself or my dependent. I authorize GlowackiMD and all associates, assistants and employees to release medical information requested by my insurance carrier, other physicians and any other third-party payers. **9. WORKERS COMP/AUTO CASES:** You must have a letter from your case manager and/or the insurance company stating that you have an "open and billable claim." We must have the date of injury and the area(s) of the body that are to be treated under the claim. We need this information at the time of your visit, and if during the course of your treatment at GlowackiMD you begin litigation and or settle your case, you are ultimately responsible for all charges. **10. SELF PAY:** If you have no insurance or have an insurance in which we do not accept, we will give you a discounted rate for services, evaluations, and treatments. All self-pay charges are due at the time of service and any payment plans/arrangements must be confirmed with the practice manager ahead of time. Please note that we do not accept any Medicaid plans, and if Medicaid is your secondary insurance policy, you will be responsible for the benefits not covered by your primary plan. **11. RELEASE OF INFORMATION:** I hereby authorize and direct GlowackiMD to release to governmental agencies, insurance carriers, and others who are financially liable for all professional and medical care, all information needed to substantiate eligibility, authorization, claim, and payment. **12. INSURANCE COVERAGE & BENEFITS:** Insurance plans, benefits, and coverage are always changing. Please note we bill as a courtesy and we make every effort to take all necessary steps on our part to get you the outstanding care at GlowackiMD

Thank you for choosing GlowackiMD to be a part of your care team!