Maryland
Pain & Spine
Associates

Name _____
Last First Middle

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

May we leave a message on your Answering Machine/Voice Mail? YES or NO

Date of Birth ____/____/_____ Age _____ Social Security Number _____-_____-_____

Please Circle One: Male Female Marital Status: S M D W

Email Address _____@_____

Pharmacy Name and Location _____

Current Employer Name _____

Employer Address _____

Emergency Contact Name _____Relationship _____

Emergency Contact Phone _____ Cell/Work _____

Referred Physician _____Phone _____

Primary Insurance _____Secondary Insurance_____

Please list any names that we may speak with regarding your care: _____

I _____, hereby authorize Ehab Shalaby, MD to apply for benefits on my behalf for covered services rendered and request that the payments from my insurance company be made directly to Maryland Pain & Spine Associates or to the party who accepts my assignment. I certify that the information that I have reported with regard to my insurance coverage is correct and I authorize the release of my medical information requested by insurance company when necessary. I, or my insurance company, may revoke in writing this authorization. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for my medical services provided when a statement is rendered.

Signature _____ Date _____

324 E, Antietam St, Suite 306A Hagerstown, MD 21740

Phone: 240.469.3002. * Fax: 240.469.3193 * www.mdpsa.com

Maryland Pain and Spine Associates – Consent / Authorizations

Patient Name:_____Date of birth:_____

Please read carefully:

- All charges (e.g. co-pay, deductibles, self-pay, etc.) are due at the time professional services are rendered.
- For those services provided and submitted to my insurance company, I hereby authorize payment of medical benefits to **Maryland Pain and Spine Associates**.
- The patient is responsible for all fees.
- The fee ticket may be used to file insurance claims.
- For minor: I understand that I am fully responsible for this minor's medical charges and agree to pay all charges for services rendered by **MPSA**.
- I hereby authorize **MPSA** to furnish information to any insurance company, or authorized agency specified, regarding information concerning my medical care.

Consent for Treatment: I authorize providers at **MPSA** to perform examinations, procedures, laboratory tests and to administer such medications as, in his or her opinion, are necessary for my care.

Patient Signature:_____ Date:_____

Consent for Medication History: I consent to the use of my medication history from participating medical information exchanges.

I have chosen to opt out of this program: Patient Signature _____ Date:_____

Ancillary Services: I understand that Meritus Medical Lab (MML) may be performing laboratory studies as ordered by my physician, and collected at **MPSA.** These studies will be billed to me by Meritus Medical Lab. I understand that my insurance may not cover these services, and that I am fully responsible for these charges.

Release of information: Often it is difficult to reach a patient to convey physician orders or test results. In this event, with your signed authorization, we would release such information to a person you designate. Please complete the section below.

I authorize **MPSA** to release any information required in the course of my examination or treatment to the following designated persons:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone #: _____ Phone #: _____

Signature: _____ Date: _____

Patient / Guardian Signature: _____ Date: _____

Maryland
Pain & Spine
Associates

Ehab Shalaby, MD, FAAPMR
Board Certified, Interventional Pain Consultant

Consent for the Treatment of Pain with Narcotic (Opiate) Painkillers

I, _____, agree to all of the following:

1) I agree to obtain prescriptions for narcotics only from the physicians or physician's assistant of Maryland Pain and Spine Associates: (MPSA)
2) I agree to use only one pharmacy for the filling of narcotic prescriptions and to supply the name, address and phone number of that pharmacy to MPSA.
3) I agree to allow MPSA to communicate with other physicians or pharmacies regarding my treatment and use of the narcotic painkillers.
4) I agree to take narcotic pain killers prescribed by MPSA only as directed.
5) I agree to follow the advice of MPSA with regards to stopping narcotic painkillers if I am asked to do so.
6) If I am a woman, I certify that I am not pregnant. I will also use appropriate measures to prevent pregnancy while taking narcotic painkillers. If I become pregnant, I will notify MPSA within 72 hours upon learning of my pregnancy. Pregnancy may warrant discontinuation of narcotic painkillers.
7) I agree to have my other physicians or healthcare providers notify us of any changes in my medical condition or treatment promptly.
8) I will attend scheduled appointments with the physicians or staff of MPSA.
9) I understand that no allowance will be made for lost or stolen prescriptions or medications.
10) I understand that MPSA will stop prescribing narcotics for any of the following reasons.
    a) I give, sell, misuse or am careless with these medications.
    b) I am non-compliant with this treatment or with this agreement.
    c) I develop rapid tolerance or loss of effectiveness from this treatment.
    d) I develop side effects considered unacceptable by MPSA.
    e) My functional activities decline.
    f) I obtain narcotics or narcotic prescriptions from anyone other than MPSA.
    g) I use alcohol while taking narcotic painkillers.
11) I agree to cooperate with treatments that can reduce or eliminate the need to take narcotic painkillers.
12) If asked, I agree to give a blood or urine sample on the day requested to screen for the appropriate use of these medications as well as the possible misuse of other substances.
13) I understand that the physicians and staff of MPSA will be reasonable, but firm in interpreting these rules to protect both the patient and the physician.
14) Questions concerning my treatment and my treatment with narcotic painkillers have been fully and completely explained to me to my satisfaction and I have all the information that I need to make an informed choice about signing this consent.
15) I further agree that I will not hold the physicians or staff of MPSA liable to any civil, administrative, judicial or criminal action that may arise from my treatment with narcotic painkillers.
16) I am aware that I may develop a withdrawal syndrome from stopping these medications, which happens to everyone: If I become psychologically dependent on these medications, I will notify MPSA for appropriate treatment.
17) I understand that narcotic painkillers may have such side effects as depression, fatigue, hormone deficiency, osteoporosis, sexual dysfunction, vasomotor instability, weight gain and in women, menstrual cycle irregularities.

_____ _____
Patient Signature MPSA Physician or Staff Signature

_____ _____
Witness Date

Pharmacy name/address/phone# _____

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Maryland Pain and Spine Associates **324 E. Antietam Street, Suite 306A** **Hagerstown, MD 21740**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Print patients full name) _____ Birth date (Mo/Day/Yr) _____

(Street address) _____ Social security number _____

(City, state, zip code) _____ Phone (Home) _____

(Parent/Guardian if patient <18 yrs old) _____ Chart # _____

At the request of the individual, I _____, do hereby authorize _____ to release:
(Print Patients Name)

SERVICE DATES REQUESTED_____

_____DISCHARGE SUMMARY	_____PATHOLOGY REPORTS	_____EMERGENCY REPORTS
_____HISTORY & PHYSICAL	_____LABORATORY REPORTS	_____ALL RECORDS
_____PROGRESS NOTES	_____RADIOLOGY REPORTS	_____LAST THREE YEARS
_____OPERATIVE NOTES	_____ECG/EEG/CARDIC CATH	OTHER_____

_____ I do ____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

_____
Name of Company/Agency/Facility/Person

Our Fax:
Our Phone:

_____
Street address

_____
City, state, zip

PURPOSE OF DISCLOSURE:

_____REFERRAL TO SPECIALIST	_____INSURANCE	_____WORKERS COMP	_____LEAVING PRACTICE
_____LEGAL INVESTIGATION	_____DISABILITY DETERMINATION	_____PERSONAL	_____RELOCATION/MOVE

OTHER (SPECIFY)_____

Please provide current telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____

Signature of individual or guardian or Personal Representative of patient's estate **Power of Attorney Must Be Attached** **Date**

NOTE: **Maryland State Laws permit a fee to be charged for copying/transfer of records. This facility has contracted with Health Port Services. You will be invoiced directly according to applicable rates by Maryland State Law. Prepayment is required prior to release of records.**

MEDICAL INFORMATION RELEASED BY DISCOVERY SUPPORT SERVICES

ENTIRE_____	LAB_____	EKG_____	_____
DS_____	EKG_____	IMMUNE_____	ROI SPECIALIST
OP_____	X-Ray_____	OTHER_____	_____
HP_____	PATH_____	_____	DATE