Medicus Pain and Spine, PLC
Personalized Pain Care

Richard K. Nadjarian, M.D., M.P.H.

Bloomfield Hills
36880 Woodward Ave., Ste 220
Bloomfield Hills, MI 48304-0920
P: 248-594-7900 | F: 248-792-3642

Canton
44633 Joy Rd., Ste 200
Canton, MI 48187-1730
P: 734-446-0337 | F: 248-792-3642

medicuspainandspine.com

Dear Patient,

Thank you for scheduling a new patient appointment with Dr Richard Nadjarian. In order to facilitate your new visit, please complete the following forms and bring them with you to your visit.

In this packet, please complete pages 2-7 and 9-12 before your appointment. The second page is demographic information for registration purposes and the pages that follow provide Dr. Nadjarian with your medical history and other pertinent information. We ask you wait until the night before to complete the pain and symptom questions so that the descriptions most accurately reflect your current condition.

You will also need to bring your Picture ID, Insurance card, and (if pertains) a referral from your Primary Care Physician, and test result reports (MRI's, CT scans, EMG's, etc.).

Please note that Copays, Co-Insurance and Deductibles are due at the time of services with no exceptions.

Medicus Pain and Spine's goal is to provide excellent care to each patient in a timely manner**. If it's necessary to cancel an appointment, we appreciate at least 24 hours notice**. Giving notice allows our practice to better utilize appointment time for other patients who may require urgent medical care.

We look forward to meeting you and having the opportunity to participate in your care.

Appreciatively,

Richard Nadjarian MD and Staff
Medicus Pain and Spine, PLC

APPOINTMENT DAY AND TIME_____

LOCATION: _____

Medicus Pain and Spine, PLC
Personalized Pain Care

Richard K. Nadjarian, M.D., M.P.H.

Bloomfield Hills
36880 Woodward Ave., Ste 220
Bloomfield Hills, MI 48304-0920
P: 248-594-7900 | F: 248-792-3642

Canton
44633 Joy Rd., Ste 200
Canton, MI 48187-1730
P: 734-446-0337 | F: 248-792-3642

medicuspainandspine.com

Temp:_____ Pain :_____ Weight :_____

Demographic Information

Name:_____Date of Birth:_____

Social Security#:_____ Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Other

Address:_____
Street City Zip

E-mail Address:_____

Employer:_____Driver's License#:_____

Home Phone:_____Alternate Number:_____Work Number:_____

Race/Ethnicity: Alaskan American Indian Asian Black Hispanic Pacific Islander White Other_____

Language spoken: English _____Other_____

Emergency Contact Information

Name:_____Relationship:_____

Address:_____
Street City Zip

Home Phone:_____Alternate Number:_____

Insurance Information

Please give card(s) to front desk along with your picture identification card or driver license

Physician Information

Primary Care Physician:_____

Address:_____Phone Number:_____

Referring Physician:_____

Address:_____Phone Number:_____

Walk in Pharmacy:_____City:_____Phone Number:_____

I understand that there is no guarantee that I will be given any medications and there is no guarantee that I will be accepted as a patient in the practice.

I hereby authorize payment of medical benefits directly to the attending physician for services rendered. Authorization is hereby granted to release information as may be necessary to process and complete my claim. I understand I am financially responsible for this account.

Signature:_____ **Date:**_____

Medicus Pain and Spine, PLC
Personalized Pain Care

Bloomfield Hills 248.594.7900
Canton 734.446-0337
Fax 248.792-3642
medicuspainandspine.com

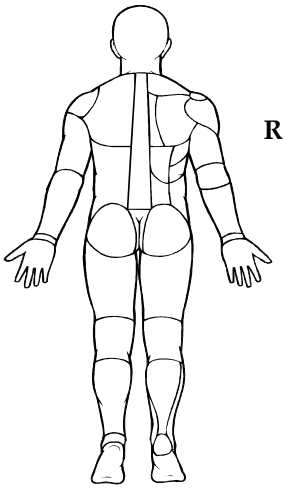
Initial Patient Assessment Form

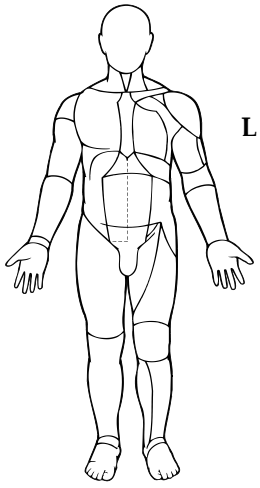
Name: _____ Age: _____ Visit Date: _____

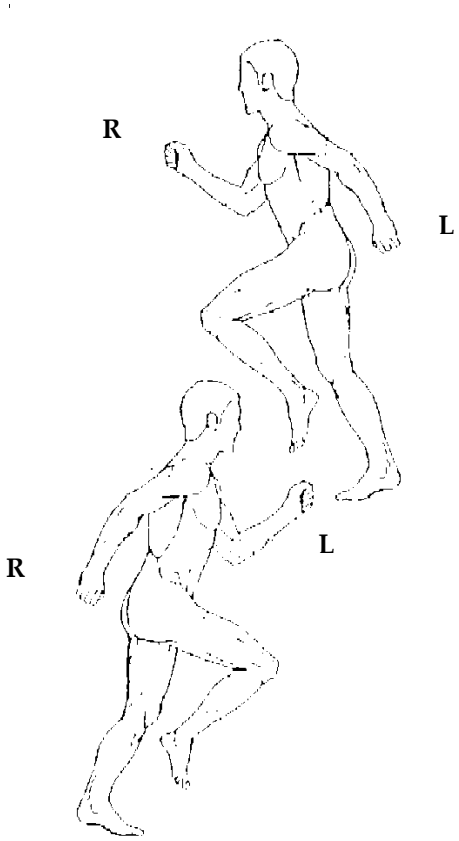
What is the main reason for your visit to the doctor today?

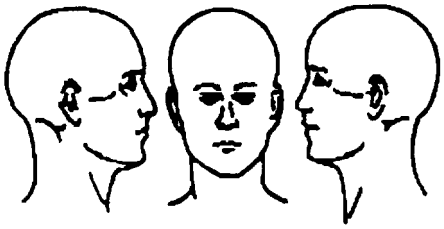
_____

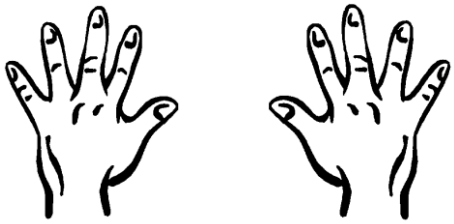
Draw an "X" on the figure below showing where your pain starts and an arrow showing where it goes.

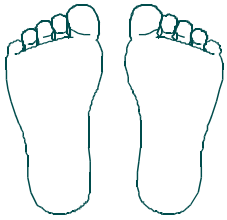












DESCRIBE WHEN AND HOW YOUR PAIN STARTED BELOW:

1. Did the pain start_____? □ Gradually □ Suddenly

2. How long have you had this pain? _____days _____weeks _____months ____years

3. What were you doing when the pain first started?

_____

_____

4. Have you had this pain in the past? □ No □ Yes
   If yes, when did the pain first start? _____

5. Is the pain_____? □ Constant □ Intermittent

6. Does the pain occur at specific times of the day? □ No □ Yes
   If yes, please explain: _____

DESCRIBE THE QUALITY OF YOUR PAIN BELOW:

My pain feels like it is (circle those that apply)…

Throbbing	Sharp	Hot-Burning
Shooting	Cramping	Aching
Stabbing	Gnawing	Dull

DESCRIBE THE INTENSITY OF YOUR PAIN BELOW:

1. Describe your pain at its **WORST**:
   0 1 2 3 4 5 6 7 8 9 10
   No Pain Worst Pain Imaginable

2. Describe your pain at its **BEST**:
   0 1 2 3 4 5 6 7 8 9 10
   No Pain Worst Pain Imaginable

3. Describe your pain on **AVERAGE**:
   0 1 2 3 4 5 6 7 8 9 10
   No Pain Worst Pain Imaginable

4. What makes the pain worse? Circle all that apply.

Bending Forward	Coughing	Prolonged Standing
Bending Back	Sneezing	Prolonged Sitting
Lifting	Changing Position	Running
Urinating	Walking	Sexual Intercourse
Defecating	Lying Down	Stress

If the above do not apply, please describe what makes your pain worse:

_____

_____

5. What makes the pain better? Circle all that apply.

Heat	Walking	Lying Down
Ice	Standing	Changing Position
Medication	Sitting	Resting

If the above do not apply, please describe what makes your pain better:

_____
_____

6. Are there other symptoms associated with the pain? Circle all that apply.

Difficulty sleeping Depression Loss of appetite Fever Weakness

TREATMENT HISTORY

1. Which of the following types of providers have you visited prior to your arrival here?

□ Primary Care Physician	□ Orthopedic Surgeon	□ Physical Medicine & Rehab
□ Rheumatologist	□ Neurosurgeon	□ Neurologist
□ Anesthesiologist	□ Chiropractor	□ Acupuncturist

□ other: _____

2. Which of the following tests have you undergone prior to your arrival here?

□ X-ray	□ CT scan	□ MRI Scan
□ Discogram	□ Myelogram	□ Diagnostic Neural Block
□ EMG	□ Bone Scan	□ Diagnostic Ultrasound

□ other: _____

3. What medications have you taken for your pain in the past?

_____

4. Which of the following treatments have you had for your pain prior to your arrival here?

□ Epidural Steroid Injections	□ Therapeutic Ultrasound
□ Trigger Point Injections	□ TENS/nerve Stimulator
□ Facet Joint Injections	□ Physical Therapy
□ Medial Branch Blocks	□ Home Exercise Program
□ Sacroiliac Joint Injections	□ Cryotherapy (Cold Therapy)
□ Radiofrequency Ablation	□ Therapeutic Heat

□ other: _____

5. Has your pain resulted in any of the following?

□ Bed Rest	□ Loss of Function	□ Worker's Compensation
□ Loss of Work	□ Litigation	□ Hiring an Attorney

If any of the above applies, please explain in further detail:

_____
_____

CURRENT MEDICATIONS (please use a separate sheet if needed)

Name	Dosage	How Often	Name	Dosage	How Often

BLOOD THINNERS: ☐ YES I am taking ☐ NO I am NOT taking ☐ NOT SURE

DRUG ALLERGIES and reactions:

_____

PAST MEDICAL HISTORY:

_____

PAST SURGICAL HISTORY with dates:

_____

FAMILY HISTORY

Mother: ☐ Living Age _____ ☐ Deceased
Health issues while alive: _____
Father: ☐ Living Age _____ ☐ Deceased
Health issues while alive: _____

SOCIAL HISTORY

1. Do you currently smoke? ☐ No ☐ Yes, _____ packs/day _____years
   If no, have you smoked in the past? ☐ No ☐ Yes, ___year quit ___packs/day ___years

2. Do you currently use alcohol? ☐ No ☐ Yes, _____drinks/day ____drinks/week
   If no, have you used alcohol in the past? ☐ No ☐ Yes, _____ year quit

3. Do you currently use recreational drugs? ☐ No ☐ Yes, type(s) _____

4. Education: ☐ Grade School ☐ High School ☐ College ☐ Post-Graduate ☐ Vocational

5. What type of work do you do? _____

6. Have you ever had exposure to toxic/poisonous substances at work or home? ☐ No ☐ Yes
   If yes, please explain: _____

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

CHILDHOOD HISTORY OF EMOTIONAL TRAUMA Mark all that apply.

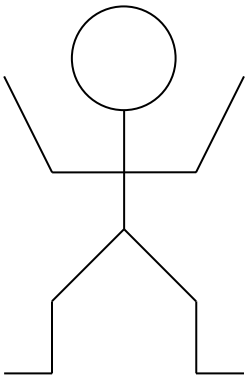
☐ Physical Abuse
☐ Sexual Abuse
☐ Emotional Abuse/Neglect
☐ Alcohol or Drug use by Caregivers

REVIEW OF SYSTEMS

Please circle the symptoms you are currently experiencing in each category. ***If no problems circle "No Problems"***

Constitutional	Fever	Weight Loss	Fatigue
No problems	Loss of Appetite	Weight Gain	Night Sweats
Cardiovascular	Chest Pain	Palpitations	Fainting Spells
No problems	Leg Swelling		
Respiratory	Trouble Breathing	Chronic Cough	Coughing Blood
No problems	Shortness of breath		
Gastrointestinal	Nausea/Vomiting	Heart Burn	Loss of Bowel Control
No problems	Diarrhea	Constipation	Blood in Stool
Genitourinary	Loss of Bladder Control	Pain on Urination	Blood in Urine
No problems			
Musculoskeletal	Muscle Cramps	Joint Pain	Joint Swelling
No problems	Loss of Muscle Bulk	Muscle Twitches	
Dermatologic	Rash	Nail Changes	Sweating Changes
No problems	Hives	Skin Discoloration	Itching
Neurologic	Headaches	Memory loss	Seizures
No problems	Weakness	Tremors	
Psychiatric	Hallucinations	High Stress Levels	Inappropriate Crying
No problems	Suicidal Thoughts		
Hematologic/Lymphatic	Abnormal bleeding	Abnormal bruising	Swollen Glands
No problems			

PLEASE DO NOT WRITE BELOW THIS LINE_____



Neck: nl_____
_____

Lungs: nl_____

Heart: nl_____

Mscsktl: nl_____
_____
_____
_____

Back/Pelvis: nl
Palpation: nl_____
_____

Sacroiliac: nl_____
_____

ROM: flex nl _____

ext nl _____

Neurologic: nl
T: R + - L + - H: R + - L + -

Strength: nl_____

Sensation: nl_____

Other: _____

_____

Medicus Pain and Spine, PLC
Personalized Pain Care

Richard K. Nadjarian, M.D., M.P.H.

Bloomfield Hills
36880 Woodward Ave., Ste 220
Bloomfield Hills, MI 48304-0920
P: 248-594-7900 | F: 248-792-3642

Canton
44633 Joy Rd., Ste 200
Canton, MI 48187-1730
P: 734-446-0337 | F: 248-792-3642

medicuspainandspine.com

HIPAA and Agreement Form

Notice of Privacy Practices Acknowledgement:

_____ Initial — I hereby acknowledge that I have been offered and/or received the Notice of Privacy Practices with which Medicus Pain and Spine, PLC complies.

Agreements:

_____ Initial **Assignments of Medical Benefits**

I understand that Medicus Pain and Spine, PLC will bill my insurance as a courtesy but ultimately, I am responsible for the entire cost of my care. I assign all rights and benefits to Medicus Pain and Spine, PLC in order to facilitate reimbursement for health care services. I will help Medicus Pain and Spine, PLC follow up on these claims. I agree to reimburse immediately for insufficient fund checks along with a $30 fee.

If collection efforts become necessary, I understand and agree that I will be responsible for the cost of collection of all unpaid amounts, including any administrative fees, billing fees, collection fees, attorney fees and court costs.

_____ Initial **General Consent to Receive Health Care Services**

I agree to receive health care services such as medical, dental, psychological, nursing, and/or other health care, which may include procedures, tests, drugs and treatment necessary to my care. I know that I have a right to discuss my care with a health care provider and that I have the right to consent or refuse to consent to any future care. My health care provider will discuss specific care/interventions including procedures with me and may obtain a specific consent. Invasive procedures and special treatments, such as immunizations or blood product administration, require specific consents. I know that the practice of medicine is not an exact science and outcomes may be different for each patient.

Patient Name: _____ DOB: _____/_____/_____

_____ _____
Patient/Parent/Legal Guardian Signature — Date

_____ _____
Patient/Parent/Legal Guardian Printed Name — Relationship

_____ _____
Witness Signature — Date

_____
Witness Printed Name

Medicus Pain and Spine, PLC
Personalized Pain Care

Richard K. Nadjarian, M.D., M.P.H.

Bloomfield Hills
36880 Woodward Ave., Ste 220
Bloomfield Hills, MI 48304-0920
P: 248-594-7900 | F: 248-792-3642

Canton
44633 Joy Rd., Ste 200
Canton, MI 48187-1730
P: 734-446-0337 | F: 248-792-3642

medicuspainandspine.com

Notice of Privacy Practices Sharing Acknowledgement:

I hereby acknowledge that I have been offered and/or received the Notice of Privacy Practices with which Medicus Pain and Spine, PLC complies.

_____ By initialing, I **DO** want my protected Health Information shared with my spouse and/or family members listed below.

Name of person(s) _____Relationship:_____

_____Relationship:_____

_____Relationship:_____

_____Relationship:_____

_____ By initialing, I **DO NOT** want my protected Health Information shared with my spouse and/or family members.

Patient Name: _____ DOB: _____/_____/_____

_____ _____
Patient/Parent/Legal Guardian Signature Date

_____ _____
Patient/Parent/Legal Guardian Printed Name Relationship

_____ _____
Witness Signature Date

_____
Witness Printed Name

Medicus Pain and Spine, PLC
Personalized Pain Care

Richard K. Nadjarian, M.D., M.P.H.

Bloomfield Hills
36880 Woodward Ave., Ste 220
Bloomfield Hills, MI 48304-0920
P: 248-594-7900 | F: 248-792-3642

Canton
44633 Joy Rd., Ste 200
Canton, MI 48187-1730
P: 734-446-0337 | F: 248-792-3642

medicuspainandspine.com

Medical Health Release Authorization

I,_____ _____
(Print Patient's Name) (Address)

authorize_____
to release information contained in my medical records, including, as applicable: information about communicable diseases and serious communicable diseases and infections, as defined by statute and Michigan Department of Consumer & Industry Services (MDCIS) (which include venereal disease "VD", tuberculosis "TB", human immunodeficiency syndrome "AIDS", and AIDS related complex "ARC"), alcohol and drug abuse treatment information protected under the regulation in 42 Code of Federal Regulations, Part 2, psychological services and social services information including communication made by me to a social worker or psychologist, to the individuals or organizations listed below, only under the conditions listed below:

1. Medicus Pain and Spine, PLC 36880 Woodward Ave, Suite 220 Bloomfield Hills, MI 48304

2. Specific information to be disclosed: _____

   _____

3. I understand that I have the right to revoke this authorization at any time expect as noted below. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the appropriate department/facility that was authorized to release information. I understand that the revocation will not apply to information that has already been released in response to this authorization of where the facility has acted in reliance upon this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. The right to revoke is also discussed in the Privacy Notice.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____ _____
Patient/Authorized Representative Printed Name Patient's Date of Birth Last 4 digits SS #

_____ _____
Witness Signature Date

_____
Witness Printed Name

Medicus Pain and Spine, PLC
FINANCIAL AGREEMENT

Dear Patient:

Thank you for choosing **Medicus Pain and Spine, PLC**, as your medical provider.

The following is our Financial Policy, which will help you with your concerns regarding our billing and payment procedures. Payment for services is due at the time service is rendered. We accept cash, checks, money orders, debit cards, MasterCard, AMEX, Visa and Discover. We will submit an insurance claim on your behalf. If your carrier is not contracted with our practice, we will courtesy bill them with the understanding that whatever the insurance does not pay; the balance is then your responsibility to pay within 30 days of your first billing statement. **IF YOU HAVE A CO-PAY, IT WILL BE COLLECTED AT THE TIME OF SERVICE.**

You are responsible for knowing your insurance/auto/work comp benefits. What are covered services in your plan? Does your insurance require a Primary Care Physician (PCP) referral? Does your physician participate in the plan? **If you are an HMO member, you are responsible for KNOWING your PCP and/or carrier.** Patients are responsible for deductible balances, co-insurance and non-covered amounts **at the time of service.** Any billed balances are due within 30 days of the statement date.

Please have **ALL INSURANCE CARDS and a PHOTO ID AVAILABLE FOR VERIFICATION AT ALL TIMES.** Any changes of insurance, address, phone number or emergency contact information should be reported immediately.

Remember that insurance authorizations/referrals for services do NOT guarantee payment. If your insurance does not pay in full within 60 days, we ask that you contact them as charges will then be transferred to you. We require you to pay the balance due even though your insurance carrier may eventually process your claim. A refund will then be mailed to you. Interest on past due balances will accrue at a rate of 1.5% monthly. There will be a $30.00 fee for all returned check items. Should your account become delinquent and be referred to a collection agency, you shall be financially responsible for the costs of collection and/or legal fees. Collection costs are calculated by adding to the principle the greater of $25 or an amount 35% in excess of the balance owed. The collection agency will contact you via information we have on file; cell phone, email, etc.

I request that payment of authorized Medicare/or any third-party benefits be made to **Medicus Pain and Spine, PLC** on my behalf for any services rendered to me. I authorize any holder of medical information about me to release to the Center for Medicare/Medicaid Services and its agents or any third-party payor any information to determine these benefits or the benefits payable for related service.

_____ _____

Printed Name of Patient/Responsible | Signature of Patient/Responsible Party

_____ _____

Patient Date of Birth | Date

Revised 1/2022