Straith Hospital for Special Surgery
23901 Lahser Road
Southfield, MI 48033-6035

PATIENT'S CONSENTS, AUTHORIZATIONS AND CONDITIONS OF ADMISSION

Patient Name: _____ Date of Birth: _____

Today's Date: _____

This document applies to care and treatment I receive at Straith Hospital for Special Surgery and its outpatient clinics, including in-person and telemedicine services (individually and collectively referred to as "Straith Hospital").

CONSENT TO MEDICAL SERVICES

I authorize and consent to medical, diagnostic, and therapeutic procedures and treatment, and authorize the physicians, mid-level professionals and other healthcare providers who may be involved in my care to provide such treatment, items and services as deemed reasonably necessary or advisable for the care I am seeking or as may otherwise be advisable for my well-being. These include, but are not limited to, diagnostic, radiology and laboratory procedures, administration of routine drugs, biologicals and other therapeutics, medical, nursing and hospital care, and telemedicine services.

I understand, acknowledge and agree that:

1. Practice of medicine is not an exact science, and that no guarantees, promises or assurances have been, or can be, made to me regarding the results that may be obtained, the likelihood of success or the consequences that may follow any in-person or telemedicine service, examination, treatment or diagnosis, or any procedure, test or surgery performed at Straith Hospital.

2. In emergency situations, it may be necessary or advisable for the physicians to perform additional or extended services beyond those contemplated at the time of admission in order to preserve my life and health, and I consent to these services.

3. My treatment and care are directed by my physician, and that the Straith Hospital personnel render care and services according to my physician's instructions. I understand that health care providers in training, including medical students and resident physicians, may be involved in my care and treatment, and I consent to their involvement.

4. The physicians on staff at Straith Hospital are not all employees or agents of Straith Hospital, and some are independent contractors or independent physicians who have been granted the privilege of using the facility for the care and treatment of their patients. I understand that a physician may not always be in the Hospital; however, there is **ALWAYS** a physician on call.

CONSENT TO TESTING

I consent to collecting specimens of my blood, urine, tissue or other bodily fluids in connection with diagnostic testing or other procedures ordered by my physician, and I authorize the examination, use, storage and disposal of all tissue, fluids and specimens removed from my body. I understand that if any health care provider at Straith Hospital sustains a percutaneous (through the skin), mucous membrane (through the mouth or eye), or open

 Patient or Patient Advocate / Representative Initials: ____

wound or other significant exposure to my blood or other bodily fluids, I may be tested for HIV (the virus that causes AIDS), Hepatitis B, Hepatitis C, and/or RPR; and I consent to such testing. The results of any such testing will be treated confidentially.

CONSENT TO THE USE OF BLOOD PRODUCTS

I consent to the use of blood, blood plasma or blood products, if the physician(s) think it is reasonably necessary. I realize that complications (including the transmission of hepatitis, AIDS or other communicable diseases) may sometimes occur unavoidably and inherently from the receipt of blood, blood plasma or other blood products.

NOTICE OF PRIVACY PRACTICES

I have received and reviewed the Straith Hospital's Notice of Privacy Practices that contains information about how Straith Hospital may use and disclose certain protected health information (or "PHI", as this term is defined by HIPAA), whether in paper, electronic, photographic and other format, that identifies me and that may consist of my past, present or future physical or mental health or condition and/or the provision of health care items or services to me. Straith Hospital may, from time to time, change its privacy practices, consistent with the requirements of HIPAA and the State of Michigan requirements.

USE AND DISCLOSURE OF HEALTH INFORMATION

Straith Hospital and its employed and other physicians authorized to provide medical services at Straith Hospital, mid-level professionals, other health care providers and staff have the right to use and disclose PHI, such as medical records and information about the appointments, tests, treatments, and/or other information pertinent to the health care or payment for the items and services provided to me at Straith Hospital, for all activities that are included within the definitions of "treatment," "payment" and "health care operations" (as these terms are defined by HIPAA) and for other lawful purposes, as described in more detail in the Straith Hospital's Notice of Privacy Practices. I understand, acknowledge and consent to the use and disclosure of my PHI for these purposes.

PROCUREMENT OF INFORMATION

I authorize Straith Hospital to obtain my PHI from other health care professionals and providers (including physicians, hospitals, nursing homes, home health agencies, pharmacies and other health care facilities) as may be necessary for my health care or to facilitate treatment, and authorize all of these health care professionals and providers to disclose my PHI to Straith Hospital. This authorization covers multiple requests for and disclosures of PHI.

PATIENT RIGHTS AND RESPONSIBILITIES

I have received and reviewed the Patient Rights and Responsibilities booklet and have had an opportunity to review its contents.

I understand that I have the right, and the responsibility, to participate in and make decisions concerning my care and treatment, including the right to refuse medical and surgical procedures. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I agree to provide accurate and complete information about my health history and present complaints, and to follow an agreed upon treatment plan. I agree to participate and cooperate in my own care and treatment. I understand that my health care providers will treat me with respect, and I agree to do the same for them.

Concerns regarding care and safety of the surgical or medical treatments being provided to me should be directed to the Hospital Compliance/Grievance Coordinator at (248) 357-3360 Extension 172. Unresolved concerns may be directed to the Michigan Department of Licensing and Regulatory Affairs (LARA) at (800) 882-6006 or The Joint Commission (TJC) at (800) 994-6610.

PATIENT PERSONAL PROPERTY

I have been informed that Straith Hospital strongly discourages bringing personal valuables, such as personal electronic devices, cell phones, money, jewelry or other articles of value, into the Hospital. I assume full responsibility for all of these items and any of my or my family members' other valuables and articles that are brought into any Straith Hospital location, and agree that Straith Hospital will not be responsible or liable for any loss or damages to any such items. I have the responsibility to store items such as dentures, glasses and hearing aids in an appropriate container that will be provided.

ADVANCE DIRECTIVE

I acknowledge receipt of Notice to Patients and Hospital's Policy Statement on Advance Directives (*Medical Treatment Decisions for Competent and Incompetent Patients*).

_____ I have an Advance Directive (*e.g.*, living will, health care surrogate declaration, durable power of attorney) and request that it govern my care if I am unable to make decisions. I understand that it is my responsibility to provide, and I agree to provide, Straith Hospital with a copy of my Advance Directive and any subsequent changes to my Advance Directive.

_____ Advance Directive attached (copy placed in Patient Chart)
_____ Advance Directive not attached (Patient / Family asked to provide)

Patient Advocate Name: _____ Contact Number: _____

_____ I do not have an Advance Directive

CERTIFICATION

I certify that I have read or had this PATIENT'S CONSENTS, AUTHORIZATIONS AND CONDITIONS OF ADMISSION form (4 pages) read and/or explained to me, that I fully understand the information, consents and authorizations provided above, that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily, and that I am the Patient listed in this document or I am duly authorized by the Patient to provide the consents and authorizations described herein and to sign this document.

References to "I", "you", "me", and "my" in this document refer to the person listed as the Patient, even though a Patient Advocate or representative signs it on behalf of or for the Patient. If this document is signed by a Patient Advocate or representative, then such person represents and warrants to Straith Hospital that he or she has the necessary power and authority to execute this document and to make decisions regarding the health care of the Patient, and agrees to indemnify, defend and hold Straith Hospital harmless in connection with any breach of this representation and warranty. Straith Hospital may and shall treat, rely and enforce all statements made by Patient's next of kin, legal agent or guardian to the fullest extent permitted by law.

I acknowledge that I can receive a copy of this form upon request.

_____ _____

Patient Signature or, if Patient is unable to sign, Signature of Patient Advocate / Representative — Date

If Patient is unable to sign, secure signature of Patient Advocate, Representative, Next of Kin and indicate reason why Patient is unable to sign: ___ Minor ___ Disoriented ___ Incompetent ___ Medically Unstable

_____ ☐ *Documents of Relationship to Patient Attached*

Name of Patient Advocate / Representative and Relationship to Patient (Please print)

_____ _____

Witness — Date

Straith HOSPITAL
COMMITTED TO YOU

REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Last name:	First:	Middle:

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name / former name?	Birth date: / /	Sex: ❑ M ❑ F	Marital status: Single / Mar / Div / Sep / Wid

Address:			
Apt./ Lot number:	City:	State:	Zip Code:

Home phone number:	Cell phone number:
Email:	Consent to text: ❑ Yes ❑ No
Language (if other than English):	
Online Patient Portal access? ❑ Yes ❑ No	Would you like to share your health information to other providers who use Athena Health Records? ❑ Yes ❑ No

How did you hear about us?

❑Referred by Dr. _____ ❑ Internet Search ❑ Insurance Company

❑Family / Friend ❑ Other_____

PHARMACY INFORMATION

Name:	Phone number:		
Address or street name:	City:	State:	Zip Code:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Phone number:

INSURANCE

Name of Primary Insurance:	Secondary Insurance:
Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	Name of Subscriber:
Subscriber DOB:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Straith Hospital or insurance company to release any information required to process my claims.

Patient/Guardian signature: _____ Date: _____

23901 Lahser Road ▫ Southfield, MI 48033 ▫ T: (248) 357-3360

PLEASE RETURN COMPLETED FORM TO A STAFF MEMBER

Straith Pain Center

NEW PATIENT FORM

Patient's Full Name: _____ Today's Date: _____

Where do you have the **MOST** pain?

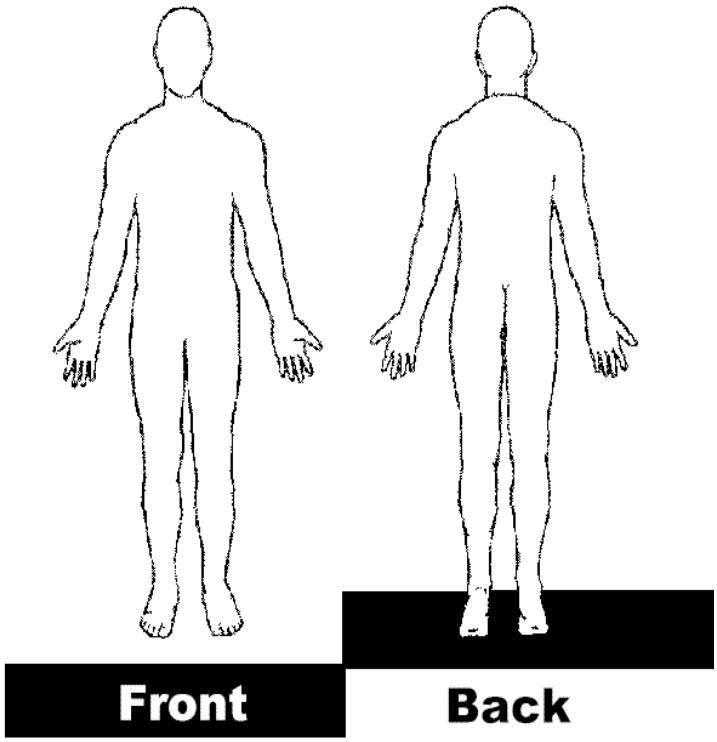
_____
(body part)

When did your pain/symptoms begin?

_____Days ____ Months ____ Years

Which side(s)? ☐Right ☐Left ☐Both

Shade in the area(s) below where you experience pain:



Description of your symptoms/pain: (check **ALL** that apply)

- ☐ Numb/Dull
- ☐ Tingling
- ☐ Sharp
- ☐ Aching
- ☐ Tender
- ☐ Heavy
- ☐ Shooting
- ☐ Stabbing
- ☐ Cramping
- ☐ Throbbing
- ☐ Exhausting/Tiring
- ☐ Hot/Burning

How did your symptoms/pain start?: (check **ALL** that apply)

- ☐ Sudden with injury
- ☐ Sudden without injury
- ☐ Gradual with injury
- ☐ Gradual without injury
- ☐ Auto Accident
- ☐ Work
- ☐ Other:_____

How often is your symptoms/pain?: (check **ALL** that apply)

- ☐ Constant
- ☐ Intermittent
- ☐ Better in AM
- ☐ Worse in AM
- ☐ Better in PM
- ☐ Worse in PM

What is the severity of your pain?:

- ☐ Mild
- ☐ Moderate
- ☐ Severe

Previous treatments: (check **ALL** that apply)

- ☐ NSAIDs (ex. Motrin/ibuprofen)
- ☐ Tylenol
- ☐ Physical therapy
- ☐ Acupuncture
- ☐ Chiropractic Treatment
- ☐ Heat/Ice
- ☐ Injection(s)
- ☐ Surgery

Other: _____

Circle your current pain score:

0	1	2	3	4	5	6	7	8	9	10
NO PAIN										WORST PAIN I CAN IMAGINE

What makes your pain BETTER: (check **ALL** that apply)

- ☐ Rest/Sleep
- ☐ Sexual Activity
- ☐ Medications
- ☐ Meditation
- ☐ Exercise/Stretching
- ☐ Walking
- ☐ Lying Down
- ☐ Working
- ☐ Social Activity
- ☐ Massage

What makes your pain WORSE: (check **ALL** that apply)

- ☐ Sitting
- ☐ Sexual Activity
- ☐ Standing
- ☐ Traveling
- ☐ Walking
- ☐ Lifting
- ☐ Sleeping
- ☐ Working
- ☐ Social Activity
- ☐ Household Chores
- ☐ Person Hygiene/Care
- ☐ Lying Down

Medications, Vitamins, and Supplements: List ALL medications you are currently taking ☐NONE

MEDICATION NAME	DOSAGE	FREQUENCY

Do you take any BLOOD THINNING medication(s)? Ex: Plavix, Coumadin, Xarelto, Eliquis, Pradaxa ☐Yes ☐No

If taking NARCOTICS / OPIOIDS (pain medication(s), do they cause impairment? ☐Yes ☐No

Are any of the following activities less painful when taking your pain medication(s)?

☐ Sitting ☐ Standing ☐ Walking ☐ Sleeping
☐ Social Activity ☐ Traveling ☐ Sexual Activity ☐ Lifting
☐ Working ☐ Household Chore ☐ Personal Care/Hygiene ☐ Lying Down

Allergies:

Are you allergic to latex? ☐NO ☐YES
Are you allergic to Penicillin? ☐NO ☐YES
Are you allergic to IV Contrast Dye? ☐NO ☐YES
Are you allergic to sulfa? ☐NO ☐YES
Are you allergic to NSAIDS? ☐NO ☐YES
Are you allergic to aspirin? ☐NO ☐YES

Please list any other allergies you may have:

_____

Family History: *Please check ALL that apply*

Anemia	☐Yes	☐No	COPD	☐Yes	☐No
Anxiety/Depression	☐Yes	☐No	Chronic Pain	☐Yes	☐No
Arthritis	☐Yes	☐No	Diabetes	☐Yes	☐No
Autoimmune Disorder	☐Yes	☐No	Mental Health Disorder	☐Yes	☐No
Bipolar	☐Yes	☐No	Heart Disease	☐Yes	☐No
Cancer	☐Yes	☐No	High Cholesterol	☐Yes	☐No
Liver Problems	☐Yes	☐No	Kidney Problems	☐Yes	☐No
Substance Abuse	☐Yes	☐No	Stroke	☐Yes	☐No

Other family history: _____

Past Surgical History: *(Please list any surgeries you have had including dates)* ☐ NO history of surgery

_____

_____

Social History:

Advanced directives: ☐NO ☐YES

Code status: ☐ Full code ☐ limited code ☐ DNR (do not resuscitate)

Work status: ☐Employed / Occupation _____ ☐Unemployed ☐Retired ☐Disabled

Smoking status: ☐ Never
☐ Former smoker; quit date: _____years smoked: _____
☐ Current smoker; packs per day: _____ years smoking: _____

Use of e-cigarette or vape products? ☐NO ☐YES If Other, what product: _____

Do you drink alcohol? ☐NO ☐YES If YES, how many drinks per week: _____

Any illegal drug use or substance abuse? ☐NO ☐YES If YES, what substance: _____

Marital status: ☐SINGLE ☐MARRIED ☐DIVORCED ☐SEPERATED ☐WIDOWED

Living arrangements: ☐LIVE ALONE ☐LIVE WITH OTHERS

Do you feel safe? ☐NO ☐YES

Able to perform activities of daily living? ☐NO ☐WITH DIFFICULTY ☐ABLE TO PERFORM

HEALTH INFORMATION

Do you have a PACEMAKER or IMPLANTED DEFIBRILATOR? ☐ YES ☐ NO

Past Medical History:

Acid Reflux (GERD)	☐Yes	☐No	Hepatitis (B or C)	☐Yes	☐No
Anemia	☐Yes	☐No	High Cholesterol	☐Yes	☐No
Anxiety	☐Yes	☐No	Hypertension	☐Yes	☐No
Arthritis	☐Yes	☐No	Irregular heartbeat	☐Yes	☐No
Asthma	☐Yes	☐No	Kidney Insufficiency	☐Yes	☐No
Autoimmune Disease	☐Yes	☐No	Kidney Stones	☐Yes	☐No
Bladder Problems	☐Yes	☐No	Liver Disease	☐Yes	☐No
Bleeding Disorders	☐Yes	☐No	MRSA Exposure	☐Yes	☐No
Blood Clot (DVT/PE)	☐Yes	☐No	Mental Health Disorder	☐Yes	☐No
COPD/Emphysema	☐Yes	☐No	Osteoporosis	☐Yes	☐No
Cancer	☐Yes	☐No	Psoriatic Arthritis	☐Yes	☐No
Chronic Pain	☐Yes	☐No	Rheumatoid Arthritis	☐Yes	☐No
Depression	☐Yes	☐No	Seizures	☐Yes	☐No
Diabetes	☐Yes	☐No	Sleep Apnea	☐Yes	☐No
Enlarged Prostate (MALES)	☐Yes	☐No	Skin Ulcers	☐Yes	☐No
Fainting Episodes	☐Yes	☐No	Stomach Ulcers	☐Yes	☐No
Fibromyalgia	☐Yes	☐No	Stroke	☐Yes	☐No
Gout	☐Yes	☐No	Substance Abuse	☐Yes	☐No
Headaches	☐Yes	☐No	Thyroid Problems	☐Yes	☐No
Heart Attack (MI)	☐Yes	☐No	Tuberculosis (TB)	☐Yes	☐No
Heart Disease	☐Yes	☐No	Ulcerative Colitis	☐Yes	☐No
Heart Stents	☐Yes	☐No			

Other health problems:

_____

Review of Systems: *Please check **ALL** that apply to your health*

Constitutional /General:
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue
- ☐ Fever

Eyes:
- ☐ Vision changes

Ears, Nose, and Throat:
- ☐ Ear pain
- ☐ Hearing loss

Cardiovascular:
- ☐ Chest pain

Pulmonary/Respiratory:
- ☐ Chronic cough
- ☐ Pain with breathing
- ☐ Difficulty breathing

Gastrointestinal:
- ☐ Diarrhea
- ☐ Nausea
- ☐ Constipation
- ☐ Abdominal/stomach pain
- ☐ Vomiting

Genitourinary:
- ☐ Burning/pain with urination
- ☐ Blood in urination
- ☐ Frequent urination

Musculoskeletal:
- ☐ Joint swelling
- ☐ Muscle aches

Integumentary/Skin:
- ☐ Rash
- ☐ Itching
- ☐ Redness
- ☐ Easily bruised

Neurological:
- ☐ Numbness/tingling
- ☐ Weakness
- ☐ Burning
- ☐ Frequent headaches
- ☐ Loss of consciousness

Psychiatric:
- ☐ Depression
- ☐ Anxiety
- ☐ Suicidal Thoughts
- ☐ Insomnia

Endocrine:
- ☐ Heat Intolerance
- ☐ Cold Intolerance

Immunologic:
- ☐ Recurrent skin rashes
- ☐ Frequent colds/flu

Questionnaire: *Please check **ALL** that apply*

1. Do you have a **family history** of substance abuse?
   Alcohol: ☐Yes ☐No **Illegal Drugs:** ☐Yes ☐No **Prescription Drugs**: ☐Yes ☐No

2. Do you have any **personal history** of substance abuse?
   Alcohol: ☐Yes ☐No **Illegal Drugs:** ☐Yes ☐No **Prescription Drugs**: ☐Yes ☐No

3. Do you have any **personal history** of any of the following?
   ADD/OCD: ☐Yes ☐No **Bipolar/Depression**:☐Yes ☐No **Schizophrenia:** ☐Yes ☐No

4. Are you between the ages of 16-45? ☐Yes ☐No

5. Were you sexually abused before the age of 13? ☐Yes ☐No

Patient/Guardian Signature: _____ Date: _____/_____/____

(Office use only) Reviewed by: _____ *Initials:* _____ *Date*: _____/_____/____

Straith HOSPITAL
Interventional Pain Center

23901 Lahser Road
Southfield, MI 48033
P: 248.386.7267
F: 248.386.7269

CONTROLLED SUBSTANCE AGREEMENT

I, _____, understand that in order to receive care for the treatment of pain or the use of controlled medications, I agree to and will comply with the following:

A. MENTAL HEALTH AND/OR PAIN MANAGEMENT CONSULTANT: A mental health assessment and/or continuing psychological therapy may be required. If I am currently involved in mental health therapy, or if I enter such therapy, I will authorize my mental health practitioner to exchange unrestricted information regarding my condition and treatment with the undersigned physician. Initial_____

B. USE OF MEDICATIONS: I will take all medications as prescribed. I will speak with the undersigned physician before making any change in either the dose or frequency of my medications. There will be no early refills of controlled medications. Narcotic pain medications must all be obtained from the same pharmacy each time (any exception must be approved by the undersigned physician). I will abstain from alcohol use while taking opioid narcotic medication. My questions regarding my treatment have been answered and I understand the risks associated with taking narcotic pain medication, to include health risks and addiction. Initial_____

C. SEEKING PRESCRIPTIONS: I will neither seek nor fill prescriptions for any controlled medication from any other health care provider unless authorized by the undersigned physician. For all of my questions regarding my medication, I will call the undersigned physician during normal business hours. Initial_____

D. MEDICAL RECORDS RELEASES: I will inform all of my health care providers that I receive pain management and will maintain an unrestricted and current medical records release on file. Initial_____

E. DRUG SCREENING: I will participate in drug screening as a part of my treatment plan. I understand that drug screening may be conducted at the discretion of the undersigned physician. Screening may include urinalysis, blood testing, pill counts, or etc. I agree to pay all costs associated with drug testing not covered by my insurance. Refusal to submit to screening at the time specified may result in termination of chronic pain management services. Initial_____

F. ILLEGAL AND NON-PRESCRIBED DRUG USE: I understand that the use of any controlled medication not prescribed by the undersigned physician or illegal drugs may result in the adjustment or termination of care. I am aware that Straith Hospital Interventional Pain Center will cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of controlled medicines. I authorize the Straith Hospital Interventional Pain Center to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. I also understand that the use of any illegal substance may result in the adjustment or termination of care. Initial_____

G. LOST OR STOLEN MEDICATIONS: I agree to safeguard all medications prescribed by the undersigned physician and understand that lost or damaged medications will not be replaced. Initial_____

H. PRESCRIPTIONS WHILE TRAVELING: The practice may provide prescriptions for up to 90 days on a case by case basis when patients are traveling out of state. Patients will have to arrange for shipment of controlled substances by their pharmacy at their own expense. Patients who will be out of state longer than 90 days need to arrange for health care at their travel destinations. Initial_____

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I. DRIVING & OPERATING EQUIPMENT: many medications can cause drowsiness and/or a very relaxed state of mind causing operation of equipment or vehicles to be dangerous. I agree to refrain from driving or operating dangerous equipment for 24 hours after any change in medication dosage and whenever I feel drowsy.
Initial_____

J. TERMINATION OF PAIN MANAGEMENT: I will no longer be eligible for care if I am in possession of illicit drugs or substances, trafficking in controlled or illegal substances, intoxicated or convicted for DUI. If I alter my prescription in any way, sell or share my medications, I will no longer be eligible for chronic pain management care. I will no longer be eligible for care if I exhibit aggressive behavior toward the physicians and staff.
Initial_____

I UNDERSTAND AND AGREE TO THE CONDITIONS OF CARE DESCRIBED ABOVE AND WILL COMPLY WITH THEM. ALL OF MY QUESTIONS ABOUT THE TERMS OF THIS AGREEMENT HAVE BEEN ANSWERED TO MY SATISFACTION. FAILURE TO COMPLY WITH ANY OF THE TERMS OF THIS AGREEMENT MAY RESULT IN IMMEDIATE TERMINATION OF SERVICE.

_____

Patient Printed Name Patient Date of Birth

_____

Patient Signature and Date

___MICHAEL DRELLES_____

Medical Care Provider Printed Name

_____

Medical Care Provider Signature and Date