INDIANA POLYCLINIC

Indiana Polyclinic

201 Pennsylvania Pkwy, Ste 200
Indianapolis, Indiana 46280

317.428.4172 Direct
317.805.5500 Phone
317.805-5501 Fax

Integrating the Following Specialties on Site:

Interventional Pain Medicine

Psychiatry

Pain Psychology

Neurology

Occupational Therapy

Support Groups

Stem Cell Therapy

Dear: **Prospective New Patient**

Welcome and thank you for choosing Indiana Polyclinic.

It is important that you read and understand the information provided in this packet. Within it you will find paperwork that needs to be completed so that we may better serve you. It is **very important** that you do the following:

New Patient Checklist

- ☐ Review the included "Is Indiana Polyclinic the Place for Me?" (the page with green background). We have prepared this document because we know we cannot fit everyone's needs. If you have questions after reading, please call (317) 428-4172.
- ☐ **Complete all of the forms in this registration packet and mail them to us at the address above.**
- ☐ Please forward, or have your previous doctor(s) forward, at least one (1) year of medical records to our office. Our address and fax are listed on this letterhead. **Please note that the providers at Indiana Polyclinic cannot write prescriptions for patients that do not provide sufficient medical history.**
- ☐ Call your insurance company to verify your benefits. If you are scheduled to see one of our Physician Assistants, please verify benefits for Dmitry M. Arbuck, MD.

If you must cancel your appointment please note that we may be unable to reschedule. All cancellations and no-shows are subject to fees as stated in our office policies.

Patients are responsible for all balances; including deductibles, co-insurance and non-covered charges. If your insurance carrier requires a co-pay, we will collect it at the time of service. For your convenience, we accept personal checks, cash, Visa, MasterCard, Discover, and American Express.

We will gladly file a claim with your health insurance carrier to reflect any services you receive during your appointment(s). Indiana Polyclinic does not accept or process secondary insurance unless that secondary insurance is Medicare or Medicaid. It is important to read and understand all policies and procedures before signing.

If you have further questions or need clarification on any of our policies, please contact the New Patient Coordinator at (317) 428-4172.

Sincerely,

The Indiana Polyclinic Team

Is Indiana Polyclinic the Place for Me?

Important Information about Indiana Polyclinic

please read this before your first appointment

It is important to understand that Indiana Polyclinic (IPC) is *not for everyone.*

First and foremost, Pain Management with medication only (without intervention, psychology and/or other modalities) is NOT provided by Indiana Polyclinic. If you are looking for a medication only solution, IPC will not agree to treat you. In addition, if your treatment is or may be covered by auto insurance, worker's compensation or another legal claim, then Indiana Polyclinic will not be able to treat you.

Indiana Polyclinic is a multi-disciplinary facility specializing in the treatment of chronic pain. In our practice we have specialists in interventional pain management, psychiatry, psychology, occupational therapy, and neurology. These providers work together with the goal of reducing patients' pain and suffering as well as restoring maximum function.

Nearly all of our patients are referred to us from other providers. They have been treated for their conditions for many years and tried all kinds of treatments and medications. Many patients come to IPC for their first appointment on dangerous medications and/or at very high doses. In these cases, the management and potential change of medications is the number one priority. These kinds of medication changes sometimes even require hospitalization. ***Because opioids prescribed chronically are not safe, it is our goal to discontinue them as soon as possible.***

Beyond medication management, Indiana Polyclinic was designed to be an integrated, head-to-toe pain treatment facility. This integrated approach allows the providers to put their heads together to come up with the best plan to make you as well as possible. Naturally, this makes sense as the best path to patient success. We believe our model is the future of how medicine will be practiced, even beyond pain.

As a patient of Indiana Polyclinic, it is your responsibility to participate in your own care. To see improvement, you must be actively involved in your care and participate in psychotherapy, physical therapy, occupational therapy and interventional treatments if they are part of your treatment plan. ***This means that you will have a treatment plan and it will consist of more than just medication management or just interventional treatment.***

As you might guess, this kind of intensive, integrated care can be expensive. While Indiana Polyclinic does accept most insurance plans, patients are held responsible for their co-pays, coinsurance, deductibles as well as any non-covered services. For some patients this can be a ***big investment in their health each month beyond any out of pocket costs for medications***. Indiana Polyclinic is an independent facility and receives no public or private financial assistance; we are 100% dependent on our collections from seeing patients.

If you still have questions, please feel free to call our New Patient Coordinator at 317-428-4172. We will be happy to answer your questions and help you decide if we are the place for you.

Directions to Indiana Polyclinic (317) 428-4172

From I-465 in Indianapolis:	From the North:
Exit at NORTH Meridian Street (U.S. 31) On the north side of the city.	Take Meridian Street/Hwy 31 South.
Proceed NORTH to 106th Street.	Stay on Meridian Street until 106th Street.
At 106th Street TURN RIGHT.	TURN LEFT on 106th Street.
At Pennsylvania Pkwy TURN RIGHT (¼ turn on roundabout) onto Pennsylvania Pkwy.	At Pennsylvania Pkwy TURN RIGHT (¼ turn on roundabout) onto Pennsylvania Pkwy.
About three blocks down (straight through the 103rd Street roundabout) look for sign on Right for entrance for the building. Patient parking is to the left.	About three blocks down (straight through the 103rd Street roundabout) look for sign on Right for entrance for the building. Patient parking is to the left.

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PERSONAL DATA FORM

Demographic Information

Legal Name: (Last, First, MI)				DOB:
Age:	Sex:	Race:	What is your primary language:	
Why are you coming to Indiana polyclinic:				

DO YOU WORK? **YES NO**		
If Yes:	What is your occupation?	
	Your Employer?	# of years in current position?
	How many hours per day? Per week?	
If No:	How long have been out of work?	
	What was your occupation?	
If you do not work, how do you spend your day?		
Are you on disability? **YES NO**	For what?	
Are you able to do household chores? **YES NO**	Explain:	

Records

Physicians from whom we should request a copy of your past records			
PCP Name:	Location:	Phone:	Fax:
Referral Name:	Location:	Phone:	Fax:
Dr Name:	Location:	Phone:	Fax:
Dr Name:	Location:	Phone:	Fax:

Health Questionaire

Rate your PHYSICAL HEALTH (circle one)	**Good Average Below Average Poor**
Rate your MENTAL HEALTH (circle one)	**Good Average Below Average Poor**
Height (approximate):	Weight (approximate):
Have you gained or lost weight recently?:	Gained _____ or Lost _____ over _____ weeks
Date of Last Medical Exam:	Date of Last Psychiatric Visit:
Name of Primary Care Physician:	Name of Psychiatrist:
PCP Phone Number:	Psychiatrist Number:

Pain Information *(If you have Physical Pain, please answer this section)*

How long have you had this pain?	_____years _____ months
How many physicians have been involved in the treatment of your pain since it began? (circle one) **0-3 4-5 6-10 11-15 16-20 More than 20**	
Approximately how many emergency room visits have you had in the past year?	
(circle the number) Between 0-10 which represents the intensity of your AVERAGE DAILY PAIN **(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)**	
How long has the pain been at this level?	_____years _____ months

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(circle the number) Between 0-10 which represents the intensity of your WORST DAILY PAIN
(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)

Circle the things that make the pain WORSE.
Sitting Standing Rest Heat Cold Walking Exercise Sex Touch Other

Circle the things that make the pain BETTER.
Sitting Standing Rest Heat Cold Walking Exercise Sex Touch Other

Circle the word(s) that best describe the type(s) of pain you are experiencing.
Sharp Dull Aching Stabbing Electrical Numbness Tingling Burning Cold Throbbing

Circle one of the following words that most accurately describes your pain.
No Pain Mild Pain Discomforting Distressing Horrible Excruciating Other

Check the nerve blocks, injections or procedures that you have had related to your pain.

Modality	How Many	When	Modality	How Many	When
___Sympathetic Block			**___Physical Therapy**		
___Facet Block			**___Acupuncture**		
___Epidural Steroid			**___Cupping**		
___Trigger Point Injection			**___Chiropractic**		
___TENS Unit			**___Massage Therapy**		
___Spinal Cord Stimulator			**___Traction**		
___Selective Nerve Block			**___Rhizotomy**		
___Intrathecal Pump			**___Other: _____**		

Hospitalizations and Past Medical History

Have you ever been hospitalized before? (circle one) **YES NO**

If yes, please explain:

Do you have any chronic medical problems? (circle one) **YES NO**

(Circle below where applicable)

Addiction	**Cancer**	**Fibromyalgia**	**High Cholesterol**	**Reflux Disease**
Anxiety Disorder	**Depression**	**Heart Disease**	**Migraines/Headaches**	**Seizures**
Arthritis	**Diabetes**	**High Blood Pressure**	**Neuropathy**	**Sleep Disorder**

If yes, please explain:

Surgery

Have you had surgery in the past (not previously mentioned) **YES NO**

If yes, please explain:

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Please review the list below. If you have now, or had in the past, a problem in any areas, please **circle** "**YES**" and explain in the space provided

GENERAL

Weight Gain/Loss	**YES**	**NO**	Please explain: _____
Night Sweats	**YES**	**NO**	Please explain: _____
Fever/Chills	**YES**	**NO**	Please explain: _____
Skin Disease	**YES**	**NO**	Please explain: _____
Head Trauma	**YES**	**NO**	Please explain: _____
Eye Disease/Poor Vision	**YES**	**NO**	Please explain: _____
Ear Pain/Hearing Disorder	**YES**	**NO**	Please explain: _____
Nose/Sinus	**YES**	**NO**	Please explain: _____
Throat/Neck	**YES**	**NO**	Please explain: _____
Jaw/Teeth/TMJ	**YES**	**NO**	Please explain: _____

LUNGS AND CHEST

Asthma	**YES**	**NO**	Please explain: _____
Emphysema	**YES**	**NO**	Please explain: _____
Lung Cancer	**YES**	**NO**	Please explain: _____
Tuberculosis	**YES**	**NO**	Please explain: _____
Pneumonia	**YES**	**NO**	Please explain: _____
Other	**YES**	**NO**	Please explain: _____

HEART AND BLOOD VESSELS

Heart Attack	**YES**	**NO**	Please explain: _____
Angina	**YES**	**NO**	Please explain: _____
High Blood Pressure	**YES**	**NO**	Please explain: _____
Heart Surgery	**YES**	**NO**	Please explain: _____
Irregular Heartbeat	**YES**	**NO**	Please explain: _____
Poor Circulation in Legs	**YES**	**NO**	Please explain: _____
Blood Clot in Legs	**YES**	**NO**	Please explain: _____
Sores that Won't Heal	**YES**	**NO**	Please explain: _____
Shortness of Breath	**YES**	**NO**	Please explain: _____
Swelling Arm/Leg	**YES**	**NO**	Please explain: _____
Other	**YES**	**NO**	Please explain: _____

URINARY/GENITAL

Kidney Stones	**YES**	**NO**	Please explain: _____
Urinary Infections	**YES**	**NO**	Please explain: _____
Difficulty Urinating	**YES**	**NO**	Please explain: _____
Dialysis	**YES**	**NO**	Please explain: _____
STD	**YES**	**NO**	Please explain: _____
Loss of Bladder Control	**YES**	**NO**	Please explain: _____
Other	**YES**	**NO**	Please explain: _____

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BONES/JOINTS/MUSCLES

Broken Bones	**YES**	**NO**	Please explain: _____
Arthritis	**YES**	**NO**	Please explain: _____
Osteoporosis	**YES**	**NO**	Please explain: _____
Fibromyalgia	**YES**	**NO**	Please explain: _____
Lupus	**YES**	**NO**	Please explain: _____
Other	**YES**	**NO**	Please explain: _____

NERVOUS SYSTEM

Headache	**YES**	**NO**	Please explain: _____
Dizziness	**YES**	**NO**	Please explain: _____
Seizures	**YES**	**NO**	Please explain: _____
Stroke	**YES**	**NO**	Please explain: _____
Brain/Spinal Cord Injury	**YES**	**NO**	Please explain:_____
Multiple Sclerosis	**YES**	**NO**	Please explain:_____
Other	**YES**	**NO**	Please explain: _____

SPINE

Neck Injury/Pain	**YES**	**NO**	Please explain: _____
Back Injury/Pain	**YES**	**NO**	Please explain: _____
Disc Problems	**YES**	**NO**	Please explain: _____
Other	**YES**	**NO**	Please explain: _____

BLOOD

Anemia (Low Blood)	**YES**	**NO**	Please explain: _____
Easy Bruising	**YES**	**NO**	Please explain: _____
Easy Bleeding	**YES**	**NO**	Please explain: _____
Transfusions	**YES**	**NO**	Please explain: _____
AIDS/HIV Positive	**YES**	**NO**	Please explain: _____
Other	**YES**	**NO**	Please explain: _____

STOMACH/ESOPHAGUS/INTESTINES

Chronic Diarrhea	**YES**	**NO**	Please explain:_____
Ulcers/Heartburn/GERD	**YES**	**NO**	Please explain:_____
Constipation	**YES**	**NO**	Please explain:_____
Red or Black Stools	**YES**	**NO**	Please explain:_____
Stomach Upset from Meds	**YES**	**NO**	Please explain:_____
Hepatitis	**YES**	**NO**	Please explain:_____
Gallstones	**YES**	**NO**	Please explain:_____
Anorexia/Bulimia	**YES**	**NO**	Please explain:_____
Loss of Bowel Control	**YES**	**NO**	Please explain:_____

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ENDOCRINE/LYMPHATIC

Diabetes	**YES**	**NO**	Please explain: _____
Thyroid Problems	**YES**	**NO**	Please explain: _____
Swollen Nodes/Glands	**YES**	**NO**	Please explain: _____
Metabolic Problems	**YES**	**NO**	Please explain: _____
Adrenal Problems	**YES**	**NO**	Please explain:_____
Other	**YES**	**NO**	Please explain:_____

PSYCHOLOGICAL

Depression	**YES**	**NO**	Please explain:_____
Memory Problems	**YES**	**NO**	Please explain: _____
OCD	**YES**	**NO**	Please explain:_____
Counseling	**YES**	**NO**	Please explain:_____
Suicidal Thoughts	**YES**	**NO**	Please explain:_____
PTSD	**YES**	**NO**	Please explain:_____
ADD/ADHD	**YES**	**NO**	Please explain:_____
Psychiatric Hospitlization	**YES**	**NO**	Please explain:_____
Eating Disorder	**YES**	**NO**	Please explain:_____
Panic Attacks	**YES**	**NO**	Please explain:_____
Hallucinations	**YES**	**NO**	Please explain:_____
Excessive Sleepiness	**YES**	**NO**	Please explain:_____
Insomia	**YES**	**NO**	Please explain:_____
Other	**YES**	**NO**	Please explain: _____

Family Medical History

Please list any major illnessess members of your family have had, and tell us which relative had them. Include: **cancer, stroke, high blood pressure, diabetes, chronic pain, depression, "nervous breakdowns", alcohol, or drugs**

	Past and Present **Medical** Problem(s)	Past and Present **Mental Health/Addiction** Problem(s)
Father:		
Mother:		
Brother(s):		
Sister(s):		
Children:		
Other Relatives:		

Circle the word(s) that best describe your childhood

Good Difficult Verbal Abuse Physical Abuse Sexual Abuse Emotional Abuse

Neglect (please explain): _____ **Other**_____

Are any of your family members currently being seen at Indiana Polyclinic?	YES	NO

If yes, who? And presenting problem?:

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PERSONAL DATA FORM

Allergies

(Please attach extra page if needed)

If you have allergic to or unable to take any medication, please list them and describe your reaction

Drug	Reaction

Medications

(Please attach extra page if needed)

Please list all medications you are currently taking, with their doses and number of times per day

Taken for Pain?	Drug	Dose/Frequency	Taken for:	Who Prescribes?
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
Please list all "over the counter" drugs, vitamins, and supplements				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				
☐ Yes ☐ No				

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Have you taken any of the following medications? (circle please)

ANTIDEPRESSANTS
Anafranil (clomipramine)
Celexa (citalopram)
Cymbalta (duloxetine)
Desipramine (norpramine)
Effexor XR (venlafaxine)
Elavil (amitriptyline)
Emsam (selegiline)
Imipramine (tofranil)
Lexapro (escitalopram)
Luvox (fluvoxamine)
Nardil (phenelzine)
Pamelor (nortriptyline)
Parnate (tranylcypromine)
Paxil (paroxetine)
Prozac (fluoxetine)
Remeron (mirtazapine)
Savella (milnacipran)
Sinequan (doxepin)
Viibryd (vilazodone)
Vivactil (protriptyline)
Wellbutrin SR, XL (bupropion)
Zoloft (sertraline)
Others

ANTI-ANXIETY
Atarax, Vistaril (hydroxyzine)
Ativan (lorazepam)
Buspar (buspirone)
Klonopin (clonazepam)
Librium (chlordiazepoxide)
Propranolol
Serax (oxazepam)
Tranxene (chlorazepate)
Valium (diazepam)
Xanax & Xanax XR (alprazolam)
Others

PSYCHOTROPIC MEDS
Abilify (aripiprazole)
Clozaril (clozapine)
Fanapt (iloperidone)
Geodon (ziprazidone)
Haldol (haloperidol)
Invega/Sustenna
Latuda (lurasidone)
Prolixin (fluphenazine)
Risperdal (risperidone)
Saphris (asenapine)
Seroquel, Seroquel XR (quetiapine)
Symbyax
Thorazine (chlorpromazine)
Zyprexa (olanzapine)
Others

ANTICONVULSANTS
Depakote (valproate Na)
Dilantin (phenytoin)
Gabitril (tiagabine)
Gralise, Neurontin (gabapentin)
Keppra (levitiracetam)
Lamictal (lamotrigine)
Lyrica (pregabalin)
Tegretol (carbamazepine)
Topamax (topiramate)
Trileptal (oxcarbazepine)
Zarontin (ethosuximide)
Zonegran (zonizamide)
Others

STIMULANTS
Adderall, Adderall XR
Concerta (methylphenidate)
Daytrana Patch (methylphenidate)
Dexedrine (dextroamphetamine)
Focalin (dexmethylphenidate)
Nuvigil (armodafinil)
Provigil (modafinil)
Ritalin (methylphenidate)
Strattera (atomoxetine)
Vyvanse (lisdexamfetamine)
Others

SLEEPING MEDS
Ambien, Ambien XR,
Intermezzo (zolpidem)
Dalmane (flurazepam)
Desyrel (trazodone)
Doxepin
Halcion (triazolam)
Lunesta (eszopiclone)
Pro-Som (estazolam)
Restoril (temazepam)
Rozerem (ramelteon)
Sonata (zalepton)
Others

MIGRAINE
Alsuma/Sumavel (sumatriptan)
Amerge (naratripan)
Axert (almotriptan)
Cafergot
DHE
Duradrin
Esgic
Fioricet, Fiorinal
Frova (frovatriptan)
Imitrex (sumatriptan)
Indocin (indomethacin)
Maxalt (rizatriptan)
Midrin
Migranal (dihydroergotamine spray)
Relpax (eletriptan)
Zomig (zolmitriptan)
Others

HEADACHE PROPHYLAXIS
Accolate (zofirlucast)
Atacand (candesartan)
Calan (verapamil)
Coreg (carvedilol)
Corgard (nadolol)
Depakote (valproate Na)
Lamictal (lamotrigine)
Lithium
O2 high flow
Singulair (montelucast)
Symmetrel (amantadine)
Tenormin (atenolol)
Topamax (topiramate)
Zonergan (zonizamide)
Others

NSADS
Advil/Motrin/ Ibuprofen
Arthrotec (diclofenac oral, Cataflam, Voltaren)
Celebrex (celcoxib)
Clinoril (sulindac)
Daypro (oxaprozin)
Dolobid (diflunisal)
Feldene (piroxicam)
Flector Patch
Indocin (indomethacin)
Lodine (etodolac)
Mobic (meloxicam)
Naproxen (Aleve, Anaprox, Naprocyn, etc)
Orudis, Oruvail (ketoprofen)
Pennsaid (diclofenac)
Relafen (nabumetone)
Toradol (ketorolac)
Voltaren Gel (diclofenac)
Others

MUSCLE RELAXANTS
Dantrolene (dantrium)
Flexeril (cyclobenzaprine)
Lioresal (baclofen)
Norflex (orphenadrine)
Norgesic, Norgesic Forte
Parafon Forte (chlorzoxazone)
Robaxin (metocarbamol)
Skelaxin (metaxalone)
Soma (carisoprodol)
Valium (diazepam)
Zanaflex (tizanidine)
Others

OPIATES (NARCOTICS)
Abstral (fentanyl citrate)
Actiq (fentanyl lozenge)
Avinza (morphine)
Codeine
Dilaudid (hydromorphone)
Embeda
Exalgo (hydromorphone)
Fentora (fentanyl tablet)
Fentanyl Patch
Hydrocodone (Vicodin, Lortab, Zydone, Maxidone, Roxicet, Norco, Vicoprofen)
Kadian (morphine)
Methadone/Methadose
MS Contin, MS IR (morphine)
Nucynta, Nucynta ER (tapentadol)
Onsolis (fentanyl film)
Opana ER/Oxymorphone
Oxycodone, Percodan (Percocet)
Oxycontin (oxycodone)
Stadol (butorphanol)
Suboxone / Subutex / Butrans / Buprenorphine
Subsys (fentanyl sublingual spray)
Talwin (pentazocine)
Tylenol #2, #3, #4, Tylox
Ultram, Ultracet (tramadol)
Others

OTHERS
Antabuse (disulfuram)
Aricept (donezepil)
Campral (acamprosate)
Clonidine
Delsym (dextromethorphan)
Enbrel (etanercept)
Eufflexxa (hyaluronate)
Exelon (rivastigmine)
Hyalgan (hyaluronate)
Imuran (azathioprine)
Namenda (memantine)
Orthovisc (hyaluron)
Piracetam
Reminyl (galantamine)
Revia (naltrexone)
Sulfasalazine
Supartz (hyaluronate)
Synvisc (hylan)
Others

Please list additional medications not on the list:

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PERSONAL DATA FORM

How many years of **education** have you completed? **Degree**(s) if college/advanced training:

Have you ever been in the **military**? **YES NO**	Rank on discharge:	Kind of discharge:
List branch of service:	# of years:	

Household

Maritial Status:(circle one) **single, steady relationship, engaged, married, seperated, divorced, widowed**	
Number of marriages (including present) for you:	Number (including present) for your spouse:
Name of spouse:	Spouse's age:
Spouse's Education(in years)	Spouse's occupation:
Are your relatives/family members supportive? **YES NO**	
Does anyone in your household have (or had) addiction problems (treated or untreated)? **YES NO**	

Children

Information about children from this or previous relationships whether they are living in your household or not:			
Name:	Age:	Sex:	Living with you? **Y N**
Name:	Age:	Sex:	Living with you? **Y N**
Name:	Age:	Sex:	Living with you? **Y N**
Name:	Age:	Sex:	Living with you? **Y N**
Is your relationship with your child(ren) good? **YES NO**			

Daily Activities

What are your hobbies?
What exercises do you participate in?
Circle the number between 0 and 10 that respresents your activity level. **(inactive) 0 1 2 3 4 5 6 7 8 9 10 (very active)**

Spirituality

Do you have a religious affliation? **YES NO**	If yes, what denomination?
Do you meditate or pray? **YES NO**	
Circle the number between 0 and 10 that respresents your involvement in religious activities. **(inactive) 0 1 2 3 4 5 6 7 8 9 10 (very active)**	
Circle the number between 0 and 10 that respresents how important spirituality is to you. **(inactive) 0 1 2 3 4 5 6 7 8 9 10 (very active)**	
Circle the number how your spirituality affects the way that you cope with problems. **(inactive) 0 1 2 3 4 5 6 7 8 9 10 (very active)**	

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Social History

Circle the number between 0 and 10 that respresents your involvement in social activities.
(inactive) 0 1 2 3 4 5 6 7 8 9 10 (very active)

Do you smoke? **YES NO** If yes, how many packs per day? How many years?

Have you tried to quit? **YES NO**

Do you use alcohol? **YES NO** About how often?

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

Did you ever use street drugs? **YES NO** (if yes, circle what type and state when last used)
Cocaine Ecstasy Heroin LSD Marijuana Meth Mushrooms PCP Speed IV or Nasal Street Drugs Spice Bath Salts

Other: Last Used:

Have you been addicted to prescription drugs? **YES NO** If yes, please explain:

Have you ever been treated for substance abuse? **YES NO** If yes, please explain:

Have you ever had (Circle all that apply) **DUI DWI PI** Drug related charges? **YES NO** If yes, when?

Have you ever had any legal problems (problems with the police)? **YES NO** If yes, explain:

Do you have any current litigation relating to your condition? **YES NO** If yes, explain:

Do you have history of bankruptcy? **YES NO** If yes, when?

Are you planning to file bankruptcy in the near future? **YES NO**

Do you think you take too much pain medication? **YES NO**

Are there other things going on in your life that affect your pain? **YES NO** If yes, explain:

Have you been to another **pain treatment** facility? **YES NO**

Have you ever been discharged from another pain treatment facility? **YES NO** If yes, explain?

Sexual History

Knowing this will better evaluate your functional level and monitor your progress

What is your sexual orientation? **Heterosexual Homosexual Bisexual**

Are you currently sexually active? **YES NO**

Circle the number between 0 and 10 that respresents your present activity.
(greatly unsatisfied) 0 1 2 3 4 5 6 7 8 9 10 (greatly satisfied)

Circle the number between 0 and 10 that respresents your ability to participate in sexual activity.
(unable to participate) 0 1 2 3 4 5 6 7 8 9 10 (actively participate)

Expectation

What are you hoping to achieve with your treatment at Indiana Polyclinic?

Patient Signature **Date**

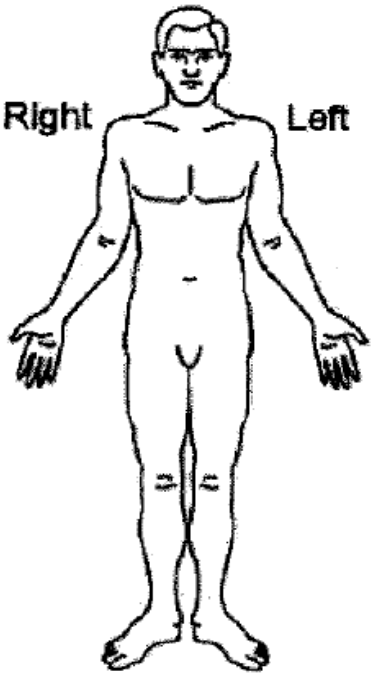
Provider Signature **Date**

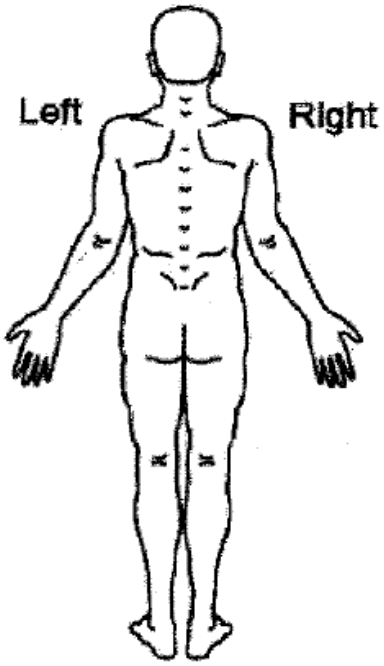
Indiana Polyclinic
201 Pennsylvania Pkwy, Ste 200
Indianapolis, IN 46280-1393

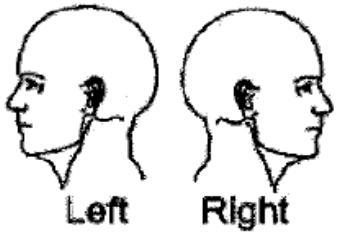
Phone: (317) 805-5500
Fax: (317) 805-5501

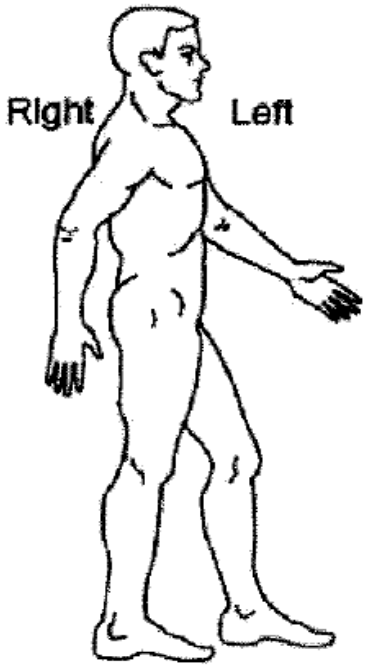
PAIN DIAGRAM

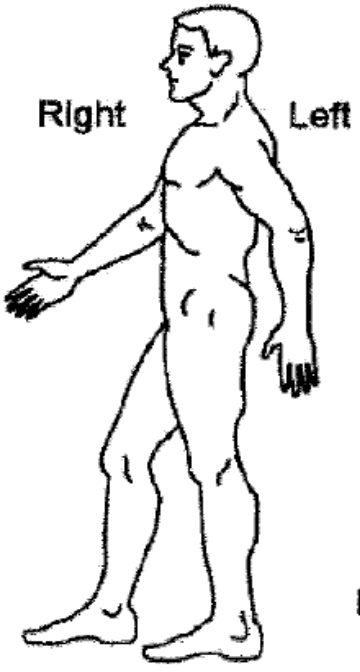
Shade the ares of pain on the following figures and add comments about your pain.

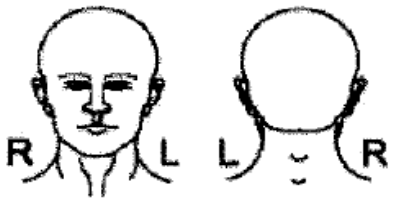


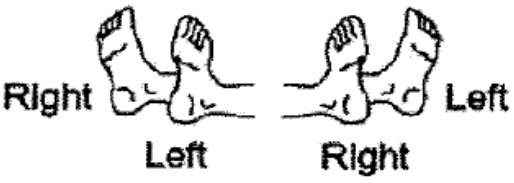












Indiana Polyclinic
201 Pennsylvania Parkway,
Suite 200
Indianapolis, IN 46280-1393

Local Phone: (317) 805-5500
Fax: (317) 805-5501

Patient Registration Form

Patient Information

Legal Name: (Last, First, MI)			Nickname:
DOB:	SSN:	Sex:	Ethnicity:
Home Address:			
Phone Numbers: Home:	Work:	Cell:	
Maritial Status:	Spouse Name:		Spouse DOB:

Employer Information

Patient Employer Name:	Phone Number:
Employer Address:	
Spouse Employer Name:	Phone Number:
Employer Address:	

Emergency Contact

Contact's Name:	Phone Number:

Policy Holder (if other than patient)

Holder's Name:	DOB:	Sex:	SSN:
Address:			
Relationship to Patient:	Phone Number:		

Primary Insurance

Insurance Name:	Claims Address:	
Policy #:	Group #:	Group Name:
Costumer Service #:	Comments:	

Secondary Insurance (only applicable if secondary insurance is Medicare or Medicaid)

Insurance Name:	Claims Address:	
Policy #:	Group #:	Group Name:
Costumer Service #:	Comments:	

Email and Text Messaging

Can we email/test you with patient notifications and/or appointment reminders? Email Address: _____ Cell # For Text Messages: _____	YES NO (please cirlce one) *Please see office policies regarding email communication.*

Accident Information

Is your treatment related to an accident? YES NO (please cirlce one)

MISSED APPOINTMENTS/CANCELLATION POLICY

IPC has a policy of charging a fee for missing an appointment or canceling with less than 24 hours notice. Office hours are Monday through Thursday 8am-7pm. This policy is explained on the first visit to IPC.

The fee for a missed appointment without 24 hours notice is $65.00, payable prior to the next scheduled appointment. I understand that if for any reason I do not keep the next two scheduled appointments without appropriate notification, I will be considered a "self-discharge" which will prevent me from scheduling any future appointments at IPC.

By initialing below, I am confirming my understanding of the missed appointment/cancellation policy and I will be responsible for paying the fee(s) when missed appointment(s) occur.

_____
Initial Here

PATIENT RIGHTS

IPC affirms equal opportunity rights and does not discriminate on the basis of age, color, national origin, race, religion, sex, physical challenges or mental challenges in admission/access to treatment. Each patient has the following unconditional rights:

- To be referred to an appropriate facility if the patient does not meet IPC admission criteria.
- To be informed of the steps involved in receiving services.
- To preserve confidentiality under federal and state laws relating to the receipt of services.
- All patients will be asked to sign a consent form for treatment. If the patient is a minor or considered incompetent, a parent or guardian will be asked to sign the consent form on his/her behalf. The facility will not provide treatment to those adults refusing service and also to minors without parental consent.
- To make an informed decision to either accept or refuse treatment. A voluntary patient is entitled to refuse treatment provided he/she has not been adjudicated incompetent. An involuntary patient who wishes to refuse treatments offered is entitled to petition the committing court or hearing office for such consideration. In the absence of such a petition, IPC may proceed with the proposed treatment. Whenever a patient gives informed consent to receive services, the consent must be made in writing and include the medical record of the patient.
- To receive humane care and protection.
- To practice his/her religion of choice.
- To contact and consult with counsel and/or private practitioners selected by the patient at his/her expense.
- To inspect and copy his/her medical record. Please note that a fee will be charged for copies of a medical record. IPC maintains the right to withhold all or part of any medical record from the patient if:

  - Withholding is necessary to protect the confidentiality of other sources of information.
  - It is determined the information requested is detrimental to the physical or mental health of the patient; or if IPC believes, the patient has potential to cause harm to him/herself or to someone else.
  - The patient's consent to inspect his/her medical record is not given freely, voluntarily, or without coercion.
  - Granting the request will cause substantial harm to the relationship between the patient and the facility, or the facility's ability to provide services in general.

A patient's review of his/her medical record shall be documented in his/hers' medical record. Any denial of the patient's right to review his/her medical record shall also be documented in his/hers' medical record, along with the reason(s) for such denial.

If your suggestion, concern or grievance is not addressed to your satisfaction, you may contact the Health Professions Bureau at 402 W. Washington Street, Room 41, Indianapolis, IN, 46204, or by phone at 317-232-2960.

All patients have the right to have all forms read to them, to ensure complete and thorough understanding.

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Initial Here

HIPPA

NOTICE OF PRIVACY PRACTICE

This notice describes how your medical information may be used and disclosed and how you can get access to this information.

Please review it carefully.

This notice of privacy practices describes how Indiana Polyclinic (IPC), its medical staff members and employees may disclose your protected health information (PHI) for purposes of treatment, payment and health care operations, and for other purposes that are permitted or required by law.

I. OUR RESPONSIBILITIES:
IPC takes the privacy of your health information seriously. We are required by law to maintain the privacy of your health information and provide you with this Notice and Privacy Practices. We will abide by the terms of this Notice of Privacy Practices.

We reserve the right to change this Notice of Privacy Practices and to make any new Notice of Privacy Practices effective for all protected health information that we maintain.

II. WHAT IS "PROTECTED HEALTH INFORMATION" (PHI)?
Protected health information (PHI) is demographic and individually identifiable health information that will or may identify the patient and relates to the patient's past, present or future physical or mental health or condition and related health care services.

III. WHAT DOES "HEALTH CARE OPERATIONS" INCLUDE?
Health care operations include activities such as communications among health care providers, conducting quality assessment and improvement activities; evaluating the qualifications, competence, and performance of health care professionals; training future health care professionals; contracting with insurance companies: conducting medical review and auditing services; compiling and analyzing information in anticipation of or for use in legal proceedings; and general administrative and business functions.

IV. HOW IS MEDICAL INFORMATION USED?
IPC uses medical records as a way of recording health information, planning care and treatment as a tool for routine health care operations. Your insurance company may request information such as procedure and diagnosis information that we are required to submit in order to bill for treatment we provide to the patient.

V. EXAMPLES OF HOW MEDICAL INFORMATION MAY BE USED FOR TREATMENT, PAYMENT OR HEALTH OPERATIONS

- Medical information may be used to justify needed patient care services, (i.e. lab tests, prescriptions, treatment protocols).
- We will use medical information to establish a treatment plan.
- We may disclose protected health information to another provider for treatment (i.e. referring physicians, specialists and other providers at IPC).
- We may submit claims to your insurance company containing medical information and we may contact their utilization review department to receive pre-certification (prior approval for treatment).
- We may use the emergency contact information you provided to contact you if the address of record is no longer accurate.
- We may contact you to remind you of the patient's appointment by calling you or mailing a postcard.
- We may contact you to discuss treatment alternatives or other health related benefits that may be of interest.

VI. WHY DO I HAVE TO SIGN A CONSENT FORM?
When you, the patient or the parent or guardian of a patient, sign a consent form, you are giving IPC permission to use and disclose protected health information for the purposes of treatment, payment and health care operations. This permission does not include psychotherapy notes, alcoholism and drug abuse treatment records and other privileged categories of information which require a separate authorization. You will need to sign a separate authorization to have protected health information released for any reason other than treatment, payment or health care operations.

VII. WHAT ARE PSYCHOTHERAPY NOTES?
Psychotherapy notes are notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session that are separated from the rest of the patient's medical record. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

VIII. WHY DO I HAVE TO SIGN A SEPARATE AUTHORIZATION FORM?
In order to release patient protected health information for any reason other than treatment, payment and health care operations, we must have an authorization signed by the patient or the parent or guardian of the patient that clearly explains how they wish the information to be used and disclosed.

IX. CAN I CHANGE MY MIND AND REVOKE AN AUTHORIZATION?
You may change your mind and revoke an authorization, except (1) to the extent that we have relied on the authorization up to that point, (2) the information is needed to maintain the integrity of the research study, or (3) if the authorization was obtained as a condition of obtaining insurance coverage. All requests to revoke an authorization should be in writing.

X. WHEN IS MY AUTHORIZATION / CONSENT NOT REQUIRED?
The law requires that some information may be disclosed without your authorization in the following circumstances:

- In case of an emergency
- When there are communication or language barriers
- When required by law
- When there are risks to public health
- To conduct health oversight activities
- To report suspected abuse or neglect
- To specified government regulatory agencies
- In connection with judicial or administrative proceedings
- For law enforcement purposes
- To coroners, funeral directors, and for organ donation
- In the event of a serious threat to health or safety

XI. YOUR PRIVACY RIGHTS
The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

1. You have the right to inspect and copy your health information.
This means you may inspect and obtain a copy of your PHI that is contained in a "designated record set" for so long as we maintain the PHI. A designated record set contains medical and billing records and any other record IPC uses in making decisions about you health care. You may not however, inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and certain PHI is subject to laws that prohibit access may be reviewable. In some circumstances, you may have the right to have this decision reviewed. Please contact our Clinic Administrator if you have questions about access to your medical record.

2. You have the right to request a restriction of your health information.
This means you may ask us to restrict or limit the medical information we use or disclose for the purposes of treatment, payment or health care operations. IPC is not required to agree to a restriction that you may request. We will notify you if we deny your request. If we do agree to the request restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by contacting our Clinic Administrator.

3. You have the right to request to receive confidential communications by alternative means or at alternative locations.
We will accommodate reasonable requests. We may also condition this accommodation by asking you for an alternative address or other method of contact. We will not request an explanation from you as the basis for the requests must be made in writing to our Clinic Administrator.

4. You have the right to request amendments to your health information.
This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with our Clinic Administrator and we may prepare a rebuttal to your statement and will provide you with a copy of this rebuttal. If you wish to amend your PHI, please contact our Clinic Administrator. Requests for amendment must be in writing.

5. You have the right to receive an accounting of disclosures of your health information.
You have the right to request an accounting of certain disclosures of your PHI made by IPC. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed by signing an authorization form, disclosures to family or friends involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Clinic Administrator. The request should specify the time period sought for the accounting. Accounting requests may not be made for periods of time in excess of six years.

6. You have the right to receive a paper copy of this Notice of Privacy Practices.

XII. WHAT IF I HAVE A QUESTION / COMPLAINT?
If you have questions regarding your privacy rights, please contact the Chief Operating Officer at (317) 428-4177.

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Initial Here

OFFICE POLICY

Welcome to Indiana Polyclinic!

At Indiana Polyclinic (IPC), our goal is to provide you with the best quality, professional, medical services. This includes treating our patients with respect, maintaining strict confidentiality (see below), and informing our patients about their condition, diagnosis and treatment options. We strive to make every patient comfortable during the treatment process and to maximize his/her level of function and quality of life.

Confidentiality

IPC takes patient confidentiality very seriously, keeping patient information and treatment plans strictly private. Confidentiality and release of records is explained in our "Notice of Privacy Practices Summary". If you would like additional privacy during check-out, please ask for a private room.

Cancellation/No Show Policy

Office hours are Monday through Thursday 8:00 a.m. to 7:00 p.m. Our office is closed Friday -Sunday. It is essential you are on-time for your appointment and call at least 24 hours in advance when you are unable to keep your scheduled appointment. Failure to show up for your appointment or cancel without 24 hours notice will result in a $65.00 charge.

Reminder Calls

Please note that while we attempt to make reminder calls for appointments, you are ultimately responsible for maintaining your appointment schedule and fees associated with failing to show up for your appointment or cancelling without 24 hours notice.

Is Indiana Polyclinic the Place for Me?

Included with this office policy is a document entitled *Is Indiana Polyclinic the Place for Me*. You must read and understand this document. It is important to understand that *IPC is not for everyone*. First and foremost, Pain Management with medication only (without intervention, psychology and/or other modalities) is NOT provided by Indiana Polyclinic. If you are looking for a medication only solution, IPC will not agree to treat you.

Prescription Refills

All prescription refill requests must be taken care of during the time of your appointment. IPC charges a $10 fee for each prescription refill request taken outside of an office visit. Please make sure at the time of your appointment that you have enough medication to last until your next visit. If you do have to leave a refill request message, please leave only one message per prescription as multiple messages for the same prescription will delay the process. We do not accept refill requests from pharmacies. Only patients may request a refill. We do not process requests for refills on Fridays, Saturdays or Sundays. After requesting a refill, please contact your pharmacy to find out when the medication is available for pickup.

After-Hours Emergencies

For after-hours psychiatric emergencies, please contact the crisis line at 317-621-5700 or dial 9-1-1. For after-hours medical emergencies, please call 9-1-1 or go to your local emergency care facility. It is important for you to take all medications with you to the emergency room.

Emergency Office Closings

Due to the unpredictability of adverse weather conditions or other emergencies, IPC reserves the right to close the office without advance notice. We will make every attempt possible to notify our patients when their appointment is cancelled in these situations, but reaching every patient may not be possible. Our after-hours voicemail system is changed frequently to reflect any changes in our office hours during an emergency situation.

Collections

If collection efforts become necessary, eligible past due balances will be sent to a collections agency. Any accounts in collections will be considered delinquent and may prevent you from scheduling future appointments and/or may result in your discharge from IPC.

Documents, Letters, Disability Forms, Depositions, etc.

Any document you request to be written, completed or filed by IPC (i.e. miscellaneous forms, disability forms, written letters, depositions, etc.) will be subject to a fee based on the type of form and the number of pages required. Documents will not be released until payment has been received.

Your Satisfaction is Important to Us

Please feel free to speak directly to your provider during office visits about any concerns you may have with your care or treatment plan.

Contact/Communication

Consent is provided to allow all information such as telephone number(s), email addresses and physical addresses to be used for communication purposes. Patient information will never be sold or provided for commercial purposes. Consent to wireless telephone calls or email utilization: if at any time I provide a wireless telephone number at which I may be contacted, I consent to communications regarding billing and payment for items and services, and/or medical information such as follow up calls or appointment reminders. In this section, calls, text messages, and emails include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, from affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

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Initial Here

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF PROTECTED HEALTH INFORMATION, CONSENT FOR TREATMENT, GUARANTY, AND STATEMENT OF SERVICE

I hereby assign and authorize payment be made directly to Indiana Polyclinic (IPC) of all of my covered health insurance benefits, including Medicare, Medicaid, Medigap, HSA, commercial, all third party payors, or private managed care plans and insurance, whether payable directly to me by any or all third party payors. I understand my health insurance plan or third party payors may not cover part or all of the medical services rendered. IPC DOES NOT BILL OR ACCEPT SECONDARY INSURANCE with the exception of Medicare as a secondary. The patient is responsible for all balances due, including those they are submitting to secondary insurance. **I fully understand I am financially responsible for and agree to pay all charges not paid by my health insurance plans or payors, including deductibles and co-insurance regardless of reason given for non-payment. I agree to immediately forward all payments, explanations of benefits, and correspondence sent directly to me from any and all third party payors related to care rendered by IPC and agree that failure to do so will make me responsible for the entire billed charge.** My assignment of benefits covers IPC physicians for all services rendered and to be rendered in the future until this assignment is revoked. This assignment of benefits **supersedes** any previous assignments or agreements I made with my insurance company, including Blue Cross Blue Shield and their related companies or any other third party payor to pay me directly. A copy of this form shall be considered as valid as the original.

I understand IPC, is a multi-specialty clinic and files claims on my behalf as a courtesy. I agree that I am financially responsible for any facility fees, laboratory test charges, and x-ray charges incurred on my behalf for care rendered. I acknowledge some or all of my care, including laboratory testing, x-rays, and physician services may be provided by out-of-network providers, and that I am financially responsible for any increased co-pays, deductibles, and non-covered services provided on an out-of-network basis.

I have disclosed the names of all my health insurance plans and third party payors, including secondary plans, and I represent such health care coverage is in full force and effect at this time. I also agree to promptly notify IPC, of any change in my health insurance plan and/or coverage as well as any changes in my address and phone number. I understand that my failure to do so will make me fully responsible for the entire bill. In consideration of the services furnished to me, I hereby agree to pay any balance due **within (30) days** from presentation of my bill. If my account should become delinquent, and collection efforts become necessary, I agree to pay 1% per month delinquency charges and any reasonable collection and/or attorney fees incurred. I further agree that Hamilton County, Indiana will be the venue for any collection efforts including small claims court and for any and all other litigation required to collect amounts due.

I understand it is ultimately **my responsibility** to obtain all required authorizations and/or precertifications for medical services that are required by my health insurance plan and/or third party payors. I acknowledge that this is **not** the responsibility of IPC. **I also acknowledge no guarantees have been made by any employee of IPC or any other party about: (1) my treatment; (2) whether it will be paid for by any third party payor(s) or health insurance plans; or (3) whether any care rendered by IPC including but not limited to physician services and radiology services are in or out of network with my insurance plans.** I agree to **fully cooperate** with IPC to assist in their efforts to get claims paid on my behalf but understand that ultimately I am financially responsible for, and agree to pay, and unconditionally guaranty payment, of all charges not paid by my health insurance plan or third party payors.

I also authorize the release of protected health information as may be required for: (1) my treatment; (2) to process insurance claims; (3) to answer any inquires from third parties that result from actions initiated by the patient; and (4) to support the operation of this medical practice. It is expressly understood this information will be used only for these purposes. **I acknowledge that I have had an opportunity to review and ask questions regarding the HIPAA privacy notice. I understand that I have the right to refuse treatment, to refuse to allow the participation of students in my care, or to refuse to participate in experimental research.**

I have read the above and consent to the terms and conditions stated.

Signature(s) of patient and/or insured	Date
Patient's social security number	Patient's date of birth