Allina Health

Dear Applicant:

At United Pain Center we offer a comprehensive approach to chronic pain management. The following components will be part of your care plan:

- A psychology evaluation to assess the psychological aspects of your pain.
- Focus on increased function through weight reduction, exercise, and smoking cessation.

If United Pain Center believes your situation could benefit from the treatment and services we offer, you will be contacted for an appointment. If it does NOT appear that your situation is appropriate for treatment at our clinic, we will not offer an appointment and will communicate this to you via letter.

Should you be accepted as a patient at United Pain Center, please note the following:

- United Pain Center does not guarantee they will continue your current treatment plan and/or the medication dosing that you may be currently receiving. If opioid (narcotic) medications are deemed to be an appropriate part of your care plan, opioids (narcotics) may only be prescribed for a limited amount of time.
- United Pain Center requires you to have established care with a primary care physician. Whenever possible, our goal is to transfer your care back to this provider when your treatment is stable.

United Pain Center Missed Appointment Policy:

New Patients: New patients who miss their initial evaluation appointment (no call) OR who do not provide more than a 24-hour notice for cancellation, will be referred back to their primary care provider. Due to high patient volume, United Pain Center will not be able to offer a second initial evaluation to patients who miss their initial evaluation appointment.

Established Patients: Any appointments that are cancelled with less than a 24-hour notice will be considered a "late cancellation". After one "late cancelation" or "missed appointment" (no call) a letter will be mailed to the patient with a reminder of the United Pain Center policy. Due to high patient volume, any additional "late cancellations" or "missed appointments" that occur, may result in the patient being discharged from United Pain Center and will be referred back to their primary care physician.

Also, because United Pain Center receives such a large number of patient referrals, there can be a lengthy waiting list. We appreciate your patience and apologize for any inconvenience this may cause.

__PLEASE NOTE:__ Patients with diabetes are asked to bring their glucometers to all appointments

Allina Health

What to do with all of the forms in this packet?

It is your responsibility to complete and return the following forms to United Pain Center within 30 days:

____ **United Pain Center intake survey.**

____ **Insurance referral information** (if your insurance requires a written referral, please obtain it from your primary care physician).

____ **Patient data form.** Please be sure to complete both sides or your initial appointment may be delayed.

____ **Release of Information form(s).** Please list any and all providers and/or specialists that have treated you in relation to your pain condition (i.e. surgeon(s), neurology, psychology, psychiatry, family practice provider(s), etc.) **including all previous pain programs** that you have participated in. We will need clinic information and fax numbers to send the releases to the appropriate parties.

____**Please be sure to include any imaging** (including EMG, CT scan, MRI and/or other x-rays pertaining to your pain) by providing us with the CD that obtains the images or complete an enclosed release of information so that we can request the medical records.

Updated: 12/2019
S412122A

Date:_____ **PATIENT DATA FORM**

Please complete this form thoroughly. If a particular section does not apply to you, please indicate so. This information is vital in order to schedule an appointment at United Pain Center. ***We will not schedule an appointment unless we have all of this information.*** Thank you.

1. PATIENT INFORMATION

NAME_____DATE OF BIRTH_____/_____/_____ Sex M F

APT#_____ADDRESS_____CITY _____

STATE_____ZIP_____RACE_____ COUNTRY OF ORIGIN_____

HOME PHONE#_____ WORK PHONE#_____CELL# _____

PREFFERED # TO CONTACT YOU _____SS# _____- _____- _____ RELIGION_____

EMAIL ADDRESS _____@_____

MARITAL STATUS (circle): Single Married Widow(ed) Divorced Separated Significant Other/Partner

2. PATIENT EMPLOYMENT INFORMATION

EMPLOYMENT STATUS: FULL PART-TIME SELF NOT EMPLOYED RETIRED

EMPLOYER_____CITY_____

PHONE_____OCCUPATION_____

3. SPOUSE/PARTNER

RELATIONSHIP TO PATIENT_____NAME_____

SS#_____-_____-_____ DATE OF BIRTH_____/_____/_____

4. EMERGENCY CONTACT (OTHER THAN LISTED)

RELATIONSHIP TO PATIENT_____NAME_____

HOME PHONE#_____CELL#_____

5. MEDICAL INFORMATION

REFERRING PHYSICIAN _____

DIAGNOSIS (BODY PART TO BE TREATED)_____

PLEASE COMPLETE BOTH FRONT AND BACK OF THIS FORM

6. INSURANCE INFORMATION

NAME OF INSURANCE: _____

POLICYHOLDER NAME: _____ DATE OF BIRTH_____/_____/_____

EMPLOYER NAME_____EFFECTIVE DATE_____

GROUP NUMBER_____ID # _____

CLAIMS MAILING ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE # TO CALL FOR BENEFITS INFORMATION (LISTED ON INSURANCE CARD)_____

7. SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE_____POLICYHOLDER NAME_____

EMPLOYER NAME_____EFFECTIVE DATE_____

GROUP NUMBER_____ ID # _____

CLAIMS MAILING ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE # TO CALL FOR ELIGIBILTY/BENEFITS (LISTED ON INSURANCE CARD)_____

YOU MUST BRING INSURANCE CARDS AND PHOTO ID TO YOUR APPOINTMENT

Allina Health

UNITED PAIN CENTER,
A DEPARTMENT OF UNITED HOSPITAL
255 Smith Avenue N. Suite 100
St. Paul, MN 55102

New Patient Intake Form

Your completed intake paperwork helps our physicians and other providers get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care. Please inquire at our front desk or call (651) 241-7246 if you have any questions on how to complete any section of this form.

Patient Information:

Today's Date: _____ Gender:_____ Date of Birth:_____

Name: _____

Referring Physician: _____

Primary Care Physician: _____

Mental Health Provider(s): _____

Pharmacy: _____

Pain History:

What is your pain condition? _____

_____

Please list any additional medical conditions? _____

_____

Onset of Symptoms:

Approximately, when did this pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin? □ Gradually □ Suddenly

Since your pain began, how has it changed? □ Improved □ Worsened □ Stayed the same

Pain Description:

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now_____ The Best It Gets _____ The Worst It Gets _____

What factors worsen or affect your pain? _____

_____

What factors relieve your pain? _____

_____

Are there any associated symptoms (numbness, tingling, weakness, incontinence, etc)? _____

_____

What is your expectation and goal of your pain management treatment? _____

_____

Diagnostic Testing and Imaging:

Check all of the following tests that you have had related to your current pain condition:

□ MRI of the: _____

Date: _____ Facility:_____

□ X-Ray of the: _____

Date: _____ Facility:_____

□ CT Scan of the: _____

Date: _____ Facility:_____

□ EMG/Nerve Conduction Velocity (NCV) study of the:

_____

Date: _____ Facility:_____

□ Other diagnostic testing: _____

□ **I have not had ANY diagnostic tests for my current pain.**

McGill Pain Questionnaire: what does your pain feel like? In each category below, check one word that best describes your current pain. Leave out categories that do not apply to you. On the diagram, shade in areas where you currently experience pain.

PROVIDER USE ONLY:

PRI: S_____ A_____ E_____M_____ PRI (T)_____PPI_____

1. ___ Flickering
___ Quivering
___ Pulsing
___ Throbbing
___ Beating
___ Pounding

2. ___ Jumping
___ Flashing
___ Shooting

3. ___ Pricking
___ Boring
___ Drilling
___ Stabbing
___ Lancinating

4. ___ Sharp
___ Cutting
___ Lacerating

5. ___ Pinching
___ Pressing
___ Gnawing
___ Cramping
___ Crushing

6. ___ Tugging
___ Pulling
___ Wrenching

7. ___ Hot
___ Burning
___ Scalding
___ Searing

8. ___ Tingling
___ Itchy
___ Smarting
___ Stinging

9. ___ Dull
___ Sore
___ Hurting
___ Aching
___ Heavy

10. ___ Tender
___ Taut
___ Rasping
___ Splitting

11. ___ Tiring
___ Exhausting

12. ___ Sickening
___ Suffocating

13. ___ Fearful
___ Frightful
___ Terrifying

14. ___ Punishing
___ Grueling
___ Cruel
___ Vicious
___ Killing

15. ___ Wretched
___ Blinding

16. ___ Annoying
___Troublesome
___ Miserable
___ Intense
___ Unbearable

17. ___ Spreading
___ Radiating
___ Penetrating
___ Piercing

18. ___ Tight
___ Numb
___ Drawing
___ Squeezing
___ Tearing

19. ___ Cool
___ Cold
___ Freezing

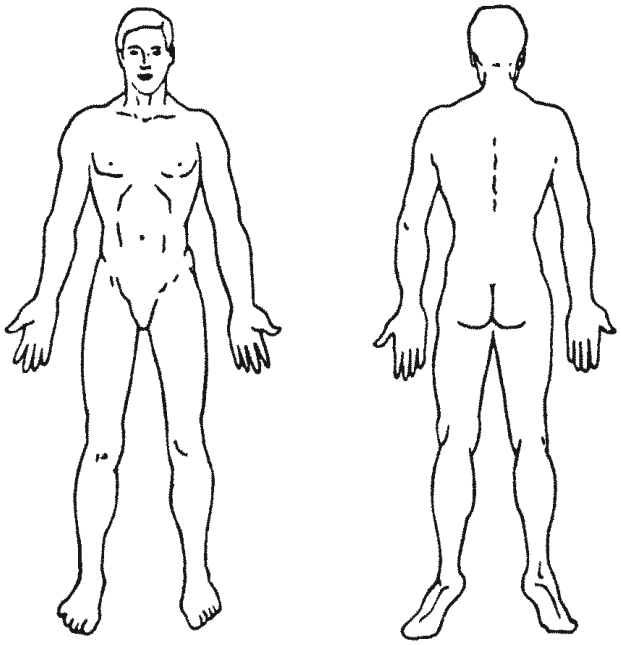
20. ___ Nagging
___ Nauseating
___ Agonizing
___ Dreadful
___ Torturing

PPI
0 ___ No pain
1 ___ Mild
2 ___ Discomforting
3 ___ Distressing
4 ___ Horrible
5 ___ Excruciating

___ Brief
___ Momentary
___ Transient

___ Rhythmic
___ Periodic
___ Intermittent

___ Continuous
___ Steady
___ Constant



Please Check All Of The Following Treatments You Have Had for Pain Relief:

	No Change	Worsened Pain	Helped Pain
Spine Surgery	□	□	□
Physical Therapy	□	□	□
Chiropractic Care	□	□	□
Mental Health Therapy	□	□	□
Brace Support	□	□	□
Acupuncture	□	□	□
Hot/Cold Packs	□	□	□
Massage Therapy	□	□	□
TENS Unit	□	□	□
Medical Cannabis	□	□	□

Interventional Pain Treatment History:

□ Epidural Steroid Injection – (circle levels that apply) Cervical/Thoracic/Lumbar

□ Joint Injection – Joint(s) _____

□ Medial Branch Blocks/Facet Injections – (circle levels that apply) Cervical/Thoracic/Lumbar

□ Nerve Blocks – Area/Nerve(s) _____

□ Radiofrequency Nerve Ablation – (circle levels that apply) Cervical/Thoracic/Lumbar

□ Intrathecal Pain Pump – _____

□ Spinal Cord Stimulator – Trial Only/Permanent Implant _____

□ Trigger Point Injections – Where? _____

□ Vertebroplasty/Kyphoplasty – Level(s)? _____

□ Other _____

Which of these procedures listed above have helped with your pain? _____

Please list the names of other Pain Physicians you may have seen in the past _____

Past Medical History:

Please check the following conditions/diseases that you have been treated for in the past:

Cancer/Oncology	ENT
□ Cancer - Type _____	□ Glaucoma
□ Cancer - Type _____	□ Vertigo
□ Cancer - Type _____	□ Hearing Problems
Cardiovascular/Hematologic	□ Nosebleeds
□ Anemia	**Respiratory**
□ Heart Attack	□ Asthma
□ Coronary Artery Disease	□ Bronchitis/Pneumonia
□ High Blood Pressure	□ Emphysema/COPD
□ Peripheral Vascular Disease	**Musculoskeletal/Rheumatologic**
□ Stroke/TIA	□ Bursitis
□ Bleeding Disorders	□ Carpal Tunnel Syndrome
□ Heart Valve Disorders	□ Fibromyalgia
□ Presence of Stent	□ Osteoarthritis
□ Presence of Pacemaker/Defibrillator	□ Osteoporosis
Gastrointestinal	□ Rheumatoid Arthritis
□ GERD (Acid Reflux)	□ Chronic Joint Pain
□ Gastrointestinal Bleeding	□ Other Arthritic Conditions
□ Stomach Ulcers	**Mental Health**
□ IBS/Crohns Disease	□ PTSD
Urological	□ Bipolar Disorder
□ Chronic Kidney Disease	□ ADHD
□ Kidney Stones	□ Depression
□ Urinary Incontinence	□ Anxiety
□ Dialysis	□ Overdose
Neurological	□ Self Harm
□ Multiple Sclerosis	□ Addiction
□ Peripheral Neuropathy	**Endocrinology**
□ Seizures	□ Diabetes - Type _____
□ Balance Disorder	□ Hyperthyroidism
□ Head Injury	□ Hypothyroidism
□ Headaches	**Other Diagnosed Conditions**
□ Migraines	□ _____
□ Stroke	□ _____

Please check the following physicians or specialists you have consulted with for your medical care:

□ Acupuncturist □ Neurosurgeon □ Mental Health Provider □ Chiropractor
□ Internist □ Orthopedic Surgeon □ Rheumatologist □ Physical Therapist
□ Neurologist □ Other _____

Past Surgical History: Please list any surgical procedures you have had in the past, including date:

1. _____
   Date: _____ Facility: _____
2. _____
   Date: _____ Facility: _____
3. _____
   Date: _____ Facility: _____
4. _____
   Date: _____ Facility: _____
5. _____
   Date: _____ Facility: _____

□ **I have never had any surgical procedures performed.**

Family History: Please check appropriate diagnoses as they pertain to your parents and siblings:

□ Arthritis	□ Cancer	□ Diabetes
□ Headaches/Migraines	□ High Blood Pressure	□ Kidney Problems
□ Liver problems	□ Osteoporosis	□ Rheumatoid Arthritis
□ Seizures	□ Stroke	

□ Other _____

□ **I have no significant family medical history**

Please use this space to provide any additional information:

_____

_____

_____

_____

_____

Social History:

Occupation: _____ When was the last time you worked? _____
□ Temporary Disability □ Permanent Disability □ Retired □ Unemployed

Are you currently under Worker's Compensation? □ Yes □ No

Is there an ongoing lawsuit related to your visit today? □ Yes □ No

Who lives in your current household? _____

Do you use any tobacco products? □ Yes □ No

If yes, what kind, how much per day? _____ Number of years _____

Do you drink alcohol? □ Yes □ No

If yes, how much? _____ How often? _____

Do you use recreational drugs? □ Yes □ No

If yes, which drugs do you use? _____

Do you think you are addicted to the use of alcohol or recreational drugs? □ Yes □ No

Do you use alcohol or recreational drugs to cope with your pain? □ Yes □ No

Have you ever been through alcohol or chemical dependency treatment? □ Yes □ No

Do you have any family members that have abused alcohol or drugs? □ Yes □ No (If Yes, who?)

_____

Check if you have ever had: _____ Blackouts _____DWI/DUI _____Injuries related to chemical use

Current Medications:

Are you currently taking any blood thinners or anti-coagulants? □ Yes □ No
If yes, which ones? □ Aspirin □ Plavix □ Coumadin □ Lovenox □ Other _____

Please list all medications you are currently taking including, vitamins. Attach additional sheet if needed

	Medication Name	Dose	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____

Please list all previously prescribed pain medications. Attach additional sheet if needed

	Medication Name	Dose	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Allergies:

Do you have any medication allergies? □ Yes □ No

If so, please list all medications that you are allergic to. Attach additional sheet if needed.

	Medication Name	Allergic Reaction
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Topical Allergies: □ Latex □ Iodine □ Medical Tape □ IV Contrast

Mental Health:

Have you ever been evaluated or treated by a mental health provider? (for example, a psychologist, counselor, family therapist, psychiatrist)

□ Yes (please describe): _____

□ No

Have you ever been diagnosed and or hospitalized with a mental health condition? (for example, depression, anxiety, panic disorder, substance use disorder, PTSD, ADHD, bipolar disorder):

□ Yes (please describe): _____

□ No

Do you have a history of self-harm?

□ Yes (please describe): _____

_____

□ No

Review of Systems: Please check & discuss symptoms you currently have:

	√	Discuss		√	Discuss
GENERAL			Black/Tarry Stool		
Unintentional wt loss			Abdominal Pain		
Unintentional wt gain			Change in Bowel Habit		
Fevers			Decreased Appetite		
Chills			**GENITOURINARY**		
Night Sweats			Painful Urination		
Excessive Fatigue			Blood in Urine		
Insomnia			Incontinence		
HEAD			Discharge		
Headache			STD History		
EYES			**MUSCULOSKELETAL**		
Vision changes			Back Pain		
EARS			Joint Pain		
Decreased Hearing			Joint Swelling		
Ringing in Ears			Joint Redness		
Earaches			Muscle Aches		
NOSE			**ENDOCRINOLOGY**		
Recurrent nosebleed			Heat/Cold Intolerance		
Sinus infections			Increased Thirst		
NECK			Change in Hair Pattern		
Stiffness			**SKIN**		
Enlarged gland			Changes in Moles		
MOUTH			Rashes		
Hoarseness			**HEMATOLOGY**		
Sore throat			Easy Bruising		
CARDIOVASCULAR			Anemia		
Chest Pain with Resting			Abnormal Bleeding		
Chest Pain with Activity			Enlarged Lymph Nodes		
Palpitations			**NEUROLOGY**		
Sleep on > 2 pillows			Headaches		
Leg Swellings			Fainting		
Hypertension			Dizziness		
Leg Pain with Exercise			Seizures		
PULMONARY			Numbness/Tingling		
Shortness of Breath			Blurred Vision		
Recurrent Cough			Decreased Memory		
Sputum Production			Abnormal Gait		
Coughing up Blood			Tremor		
Asthma/Wheezing			**GYNECOLOGY**		
Tuberculosis Exposed			Abnormal Periods		
GASTROINTESTINAL			Heavy Periods		
Nausea/Vomiting			**MENTAL HEALTH**		
Diarrhea/constipation			Depression		
Red blood in stool			Anxiety		
			Nervousness		

Allina Health

WORKERS' COMPENSATION (W/C) / MOTOR VEHICLE ACCIDENT (MVA) / THIRD PARTY LIABILITY (TPL) INFORMATION

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____

Address: _____
Street *City* *State* *Zip*

- The applicable section(s) of this form must be filled out completely in order for us to process your claim through a Workers' Compensation Motor Vehicle or Third Party Liability Insurance Company.
- You will need to get this information from your employer, work comp adjuster or insurance agent. We will need to have all information indicated below before your visit can be billed to insurance.
- **If we do not receive this form back within 30 days, you may be billed for these charges.**

Claim Number: _____ Date of Injury/Accident: _____

Body Part(s) involved: _____ What side of body injured? ☐RIGHT or ☐LEFT

Place of injury: ☐Home ☐Work ☐Other Address of injury location: _____

Has your claim been Denied (W/C) or Benefits Exhausted (MVA)? ☐YES or ☐ NO

Do you have an Attorney? ☐YES or ☐ NO Name: _____ Phone #: _____

Do you have a W/C QRC? ☐YES or ☐ NO Name: _____ Phone #: _____

For Worker's Compensation (W/C)

- If you do not know the name of your employer's workers' compensation insurer or the claim number, ask your employer, or call the Department of Labor and Industry at 800-342-5354 (toll-free), or 651-284-5032.

Employer at Time of Injury: _____ Employer Phone: _____

Employer Fax: _____ Has 1st Report of Injury been filed? ☐YES ☐NO

Employer Address: _____
Street *City* *State* *Zip*

W/C Adjuster Name: _____ W/C Adjuster Phone # _____

W/C Insurance Name: _____ W/C Adjuster Fax# _____

W/C Billing Address: _____
Street *City* *State* *Zip*

For Motor Vehicle Accident (MVA) / Third Party Liability (TPL)

State Accident Occurred: _____

Name of Insurance Policy Holder: _____ Policy Holder Date of Birth: _____

MVA/TPL Insurance Contact name: _____ MVA/TPL Phone# _____

MVA/TPL Insurance Co. name: _____ MVA/TPL Fax # _____

MVA/TPL Billing Address: _____
Street *City* *State* *Zip*

- Provide us this info by calling 612-262-9000 or fax the completed form to 612-262-4077 Attn: Customer Service.
- You can also mail it to us: Allina Health, Attn: Customer Service, PO Box 43 MR 10209, Minneapolis, MN 55440
- You can also email it to us at SubmitDocument@allina.com

S413141

ALLINA HEALTH
AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

Internal Use Only	Completed By Initials : _____ Date: _____

PATIENT INFORMATION

Patient name			Date of Birth
Street Address		Email Address	
City	State	Zip Code	Phone Number

RELEASE MY MEDICAL RECORDS FROM ****check one option**

☐ Allina Health (optional: specify location or provider below):	**OR**	☐ Hospital/Clinic/Provider (required: specify name below)	
Street Address		Phone Number	
City	State	Zip Code	Fax Number

SEND MY MEDICAL RECORDS TO ****address field is required**

Person/Business/Hospital/Clinic	Phone Number	Fax Number	
Street Address	City	State	Zip Code

PURPOSE FOR RELEASE

☐ Continuing Care ☐ Personal Use/Review * ☐ Litigation/Legal * ☐ Insurance Application * ☐ Insurance Payment/Claim
☐ Social Security Disability * ☐ Social Security Appeal ☐ Disability Insurance ☐ Other * _____

**Fees may be charged in accordance with MN Statute 144.2923 and Federal Rule 45 C.F.R. §164.524*

INFORMATION TO BE RELEASED:

I want my records related to: _____

I want my records for dates of service: _____

☐ Billing Records* ☐ Community Pharmacy* ☐ Pathology Slides/Blocks* ☐ Radiology Images* (**Will be sent separately)*

What Information do you want disclosed?

☐ Clinic Record Set (office visit notes, lab, radiology report, med list, immunizations)
☐ Hospital Record Set (history & physical, discharge summary, operative report, consultations, emergency records, lab, radiology report)

Individual Report Options:

☐ Discharge Summary/Note	☐ Clinic/Progress Notes	☐ Laboratory Reports	☐ Immunization Record
☐ History & Physical Exam	☐ Emergency/Urgent Care	☐ Pathology Reports	☐ Allergy Record
☐ Operative Report	☐ Rehab Notes (PT/OT/ST/RT)	☐ Radiology Reports	☐ Medication Records
☐ Consultations	☐ Home Health/Hospice	☐ EKG/ECHO	

☐ Any and All Records (includes ALL types of records at Allina Health) ☐ Other Records (specify type): _____

Special Disclosure Permissions

☐ Chemical Dependency/Substance Use Program Records ☐ Genetic Counseling Records
Wisconsin Records Only: ☐ Mental Health Records ☐ HIV Test Results

RELEASE METHOD/FORMAT

► **Date Records are Needed (appointment date):** ____ / ____ / ____ **(NOTE: PLEASE ALLOW 7-10 DAYS FOR PROCESSING)**

☐ Allina Health My Account (MyChart) ☐ U.S. Mail (Paper) ☐ U.S. Mail (CD/DVD) ☐ Fax (Patient Care Only-See Above)
☐ Non-Secure Email* (to Patient Only-See Above) ☐ Secure Email : _____
☐ Verbal (no records will be sent) ☐ Pick Up at Allina Health Commons (by appt only) ☐ View Record

**NOTE: I acknowledge that by electing to receive my health information via email in a non-secure manner that the information will not be encrypted, and that it could be intercepted and viewed by a third party. Allina Health is not responsible for unauthorized access of your health information while in transmission to the email address you designated above.*

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____ /_____ / _____
  This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. The Allina Health Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- Allina Health will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- Allina Health records may include records that it received from other organizations. If these records have been used by Allina Health and filed in the record Allina Health maintains about you, these records may be released with your Allina Health records.
- Allina Health cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release Allina Health from any and all liability resulting from a redisclosure by the recipient.
- Federal Rule 42 CFR part 2 prohibits unauthorized disclosure of Substance Use Program Records
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

Patient/Legal Guardian Signature	Date	Authority to act on behalf of patient (attach document)

Directions for Completion of Form

Patient Information: Complete the entire section which identifies clearly and legibly all of the demographic information specific to the patient (individual about whom information is being requested)

Release My Medical Records From: Check the first box if you would like your records released from an Allina Health facility/provider. Check the second box if you are requesting your records be released from a **non**-Allina Health facility/provider. When checking the Allina Health option, please specify the specific Allina Health location you are seeking information from. **Please be specific** in your request. For example, United Hospital, St. Paul, MN; Buffalo Hospital, Buffalo, MN; Allina Medical Clinic Shoreview, Shoreview, MN. If you do not identify a specific hospital or clinic (e.g. Allina Health), records may be provided from ***ALL*** Allina Health hospitals or clinics where you have received care. Please see allinahealth.org/medical records for a listing of Allina Health hospital and clinic locations and addresses.

Send My Medical Records To: Identify the full name/business, address, phone and contact information with the name of the individual who is *to receive* the information. *Please allow 7-10 days for all requests to be processed and sent to the recipient*.

Purpose For Release: Please identify why you need a copy of your record. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).

Information to Be Released: This section gives us the instructions for what information you want released. If you select "Clinic Record Set" or "Hospital Record Set", we will disclose the pertinent documents that are specific to that type of patient care visit. This is typically what doctors' offices, hospitals or other health care providers need to provide information related to your care. If you select "any and all" records, your entire record will be provided for a specific visit date or all dates. It is very helpful if you identify the date or range of dates, needed by the requestor. Please note record types listed in the Special Disclosure Permissions section must be checked in order for them to be released.

Release Method: This tells us how you would like your information delivered. If you wish to view information prior to selection of documents, please identify this on the authorization form and we will contact you to set up a viewing appointment. Please note that viewing appointments are done at the Allina Health Corporate Office in Minneapolis. If you wish information about you to be shared verbally or for an authorization to be on file for others to have access to your medical information, please write this in this section (example: form on file for access by my husband upon his specific request). Please note: there are size limitations when emailing records.

Duration of the authorization, revocation and other information you need to know: This authorization will automatically expire in 12 months **unless** you include a different date. You may indicate the authorization is valid "5 years", "10 years", but there needs to be an ending date (do **not** use terms such as "lifetime" or "forever"). The authorization can be revoked by your written direction to our organization.

Contact Information for Patient Record Copies
*****Incoming medical records are not to be sent to this department*****

Allina Health
Attn: Health Information/ROI – Mail Route 10203
PO Box 43
Minneapolis, MN 55440-0043
Phone: 612-262-2300
Fax: 612-262-2323
Email: MedicalRecords@allina.com

Contact Information for Allina Health Pharmacy Charges Copies Allina Health Pharmacy – Mail Route 10807

Allina Health
PO Box 43
Minneapolis, MN 55440-0043
Phone: 612-262-5980
Fax: 612-262-5988

For a list of Allina Health locations and addresses, please visit allinahealth.org

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Plate: Black

IMPORTANT INFORMATION ON BILLING

United Pain Center is an outpatient department of United Hospital; not a physician owned clinic. **Because of this, your insurance company will receive two bills for each visit.** One bill will be for hospital charges, and one bill for provider charges.

This is confusing for many people because we are not located in the hospital building. The facility/hospital component is for overhead costs (nursing and ancillary staff rendering services, equipment used to render services, and routine supplies). The professional component is for the services of the physicians, nurse practitioners, and psychologist.

Because we are a hospital facility, your insurance may apply a higher copay or deductible to your visits.

If you have a Workman's Compensation claim it is your responsibility to ensure your visits are authorized.

United Pain Center is an outpatient hospital facility. Please check with your insurance company regarding your coverage for outpatient hospital services.

- Billing questions can be answered by:
  Allina Patient Financial Services at 612-262-9000.

It is recommended you save this form for future billing questions.