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Pain Management and Injury Relief

Patient Registration Agreement

Personal Information (*Please Print*):

Name:_____ Social Security No._____
Home Address:_____ City:_____ State/Zip:_____
Home Phone:_____ Cell:_____ D/L #:_____
Employer:_____ Occupation:_____
Work Address:_____ City:_____State/Zip: _____
Work Phone:_____ Email: _____
Gender: □ M □ F DOB:_____ Age:_____
Marital Status: □Single □Married □Divorced □Widowed
Race: □ American Indian/Alaska Native □ Asian □ Native Hawaiian
□ Other Pacific Islander □ White □ African American
□ More than one race □ Prefer not to answer
Ethnicity: □ Hispanic/ Latino □ Non Hispanic/ Latino □ Prefer not to answer
Language: _____
Emergency Contact: _____ Relationship:_____
Phone # Home: _____ □ Cell: _____ □ Work:_____

Primary Insurance

Insurance Company Name _____ Subscriber #_____ Group #_____
Address _____City_____State/Zip _____
Name of Subscriber (*if other than Patient*) _____ Relationship_____
Subscribers Date of Birth_____

****** PLEASE SUBMIT YOUR INSURANCE CARD AND PICTURE ID WITH THIS FORM ******

Secondary Insurance

Insurance Company Name _____ Subscriber #_____ Group #_____
Address _____City_____State/Zip _____

ASSIGNMENT OF INSURANCE BENEFITS

I CERTIFY THAT I HAVE INSURANCE COVERAGE WITH THE ABOVE INSURANCE CARRIER(S) AND HEREBY AUTHORIZE PAIN MANAGEMENT INJURY RELIEF MEDICAL CENTER TO RE-LEASE TO THE CARRIER(S) ANY INFORMATION THAT IS NECESSARY TO OBTAIN INSURANCE BENEFITS. I ASSIGN TO PAIN MANAGEMENT INJURY RELIEF MEDICAL CENTER, ALL MY RIGHT, TITLE, AND INTEREST IN AND TO ANY AND ALL HEALTHCARE BENEFITS OTHERWISE PAYABLE TO ME FOR ANY MEDICAL TREATMENT, RENDERED BY PAIN MANAGEMENT INJURY RELIEF MEDICAL CENTER AS DESCRIBED IN THE ATTACHED MEDICAL CLAIM FORM. I UNDERSTAND THAT **I AM FINANCIALLY RESPONSIBLE** FOR ALL CHARGES INCURRED, WHETHER OR NOT PAID BY INSURANCE AND AGREE TO PAY ANY APPLICABLE DEDUCTIBLE AND CO-PAYMENT AMOUNT NOT COVERED BY MY INSURER, PLAN OR PAYER.

I UNDERSTAND THAT MY INSURANCE COMPANY MAY ISSUE A CHECK FOR SERVICES PROVIDED BY PAIN MANAGEMENT INJURY RELIEF MEDICAL CENTER, TO MY SELF OR POLICY HOLDER, (*AS THEY ARE AN OUT OF NETWORK PROVIDER*). AS PART OF THIS ASSIGNMENT I AUTHORIZE THE PROVIDER TO ENDORSE ANY CHECK MADE PAYABLE TO THE PROVIDER AND TO MYSELF FOR SERVICES RENDERED. IN ADDITION, I AGREE TO ENDORSE ANY INSURANCE CHECK SENT TO ME BY MY INSURANCE CARRIER FOR SERVICES RECEIVED AND FORWARD TO PAIN MANAGEMENT INJURY RELIEF MEDICAL CENTER (*WITHIN 10 DAYS UPON RECEIPT OF SUCH CHECK*).

IF I DEPOSIT SUCH A CHECK INTO MY PERSONAL ACCOUNT, I AGREE TO SEND PAIN MANAGEMENT INJURY RELIEF MEDICAL CENTER A PERSONAL CHECK FOR THE EQUIVALENT AMOUNT. FAILURE TO REMIT PAYMENT WITHIN THE GIVEN TIME FRAME CAN RESULT IN COLLECTIONS EFFORTS BY THE PROVIDER, OUTSIDE COLLECTIONAGENCY, AND/OR LEGAL ACTION.

Signed_____ Date_____

Print Name_____

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If not signed by Patient (√): □ Parent (for a minor) □Guardian Minor/Other □ Spouse □ Beneficiary/ Representative

I agree to be treated by the staff at Pain Management and Injury Relief Medical Center. I may be contacted at any of the addresses and phone numbers given. I understand the reasons for contact are for appointment reminders, test results, and other matters related to my health. I have not included any phone numbers or addresses that I would not want my health professional to reference or use. I have read and Understand that Pain Management and Injury Relief is *OUT OF NETWORK* with my Insurance Company (except Medicare and some HMO's) and that I may receive payment from my Insurance Company, and that I am fully responsible for forwarding that payment to "Pain Management Injury Relief Medical Center" with in 10days of receipt of said payment and copy of attached EOB (Explanation of Benefits). I understand that I am fully responsible for my deductibles and co-pay as outlined in my Insurance policy and any NON-COVERED Services (Not medically necessary, denied, etc.).

INITIAL_____

CANCELLATION POLICY:

In the event that you should need to reschedule or cancel your appointment, we ask that you please notify us at least 24 hours prior to your scheduled appointment time. If an appointment is not cancelled at least 24 hours in advance, you will be charged a **$25 CANCELLATION Fee.** There is a $50 **NO SHOW Fee** (if you fail to arrive for your scheduled appointment).

All Appointments are confirmed prior to appointment date. **INITIAL**_____

COPIES of RECORDS:

I Understand that there is a $25 charge for copies of my medical records, extra copies of medical billing, beyond what has already been submitted to my Insurance Company. **INITIAL** _____

Notices of Privacy Practices:

The Notice of Privacy Practices describes how Pain Management & Injury Relief Medical Center will use and disclose your Protected Health Information to provide treatment, to obtain payment, or for other purposes necessary to operate this medical practice.

Your Protected Health Information includes reason(s) for your admission, type of care and treatment you may receive, other information, including demographic information (e.g. your home address, age, gender, and so forth) that maybe necessary or helpful to identify you, or to assist your Physician and others to provide necessary medical care.

A Copy of our Notice of Privacy Practices is given to you upon admission or 1st day of service, whichever is earlier.

(Please see attached) **INITIAL** _____

ARBITRATION:

Attached you will find our Physician –Patient Arbitration agreement. By signing this agreement, you are agreeing that any dispute arising out of medical services you receive is to be resolved by binding arbitration rather than litigation.

Lawsuits are something that no one anticipates and hope to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians.

Arbitration agreements between healthcare providers and their patients have long been recognized and approved by the California Courts.

By signing the attached agreement, you are changing the process by which your claim will be resolved (this does not take away your rights). You may still call witnesses and present evidence. Each party selects an arbitrator (called Party arbitrators), who then select a third, neutral arbitrator. These three arbitrators then hear your case.

This agreement generally helps to limit the legal costs for both patients and physicians. This also can spare some of the rigors of trial and the publicity that may accompany judicial proceedings.

Our Goal is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. If you have any questions about your care…***PLEASE ASK***. **INITIAL** _____

Please print and sign below for acknowledgement of Pain Management and Injury Relief's patient registration agreement.

_____ □ Self □ Parent □ Representative/Guardian

PRINT: Patient/Representative Name

_____ _____

Signature Date

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MEMBER AUTHORIZATION FORM FOR A DESIGNATED REPRESENTATIVE TO APPEAL A DETERMINATION

To: **Insurance Carrier**

Date:_____

Member Name: _____

Member Insurance ID Number: _____

I hereby authorize: _Pain Management and Injury Relief_ to appeal Insurance Carriers determination concerning

_____

On my behalf, as my Designated Representative, and as a part of the appeal. I hereby authorize Insurance Carrier in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain the following:

> All medical and financial information contained in my insurance file, including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed.

I understand this information is privileged and confidential and will only be released as specified in this Authorization, or as required or permitted by law. This authorization is valid for a period of one year.

_____
Signature of Member or Legal Guardian/Representative

_____
Signature of Witness_____ **OR** Designated Representative_____

_____
Print Name of Witness/Designated Representative

_____
Title (if on Providers staff) OR Relationship to Member

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ASSIGNMENT OF BENEFITS

Name of Insured (print): _____

Insurance Co. Name: _____

Policy Number: _____

I, hereby assign to **Pain Management and Injury Relief** all my right, title, and interest in and to any and all health care and/or surgical benefits otherwise payable to me for medical treatment, including major medical, rendered by the assignee as described in the attached medical claim form.

I acknowledge that my insurance company may issue a **check** and **explanation of benefits** for services provided by **Pain Management and Injury Relief** directly to myself or my policy holder. As part of this assignment I authorize the provider to endorse any **check** made payable to the provider and to myself for services rendered. In addition, I agree to endorse any insurance **check** sent to me by my insurance carrier for services received from the above provider and forward both the **check** and **explanation of benefits** to **Pain Management and Injury Relief** within *5 days* upon receipt of such **check**. If I deposit such a **check** into my personal account I agree to send to **Pain Management and Injury Relief** a **check** for the equivalent amount along with the **explanation of benefits**. Failure to remit payment within the given time frame can result in collections efforts by the provider, outside collection agency, and/or legal action.

I acknowledge that it is my responsibility and agree to pay any applicable deductible and co-payment amount not covered by my insurer, plan, or payer.

Signed: _____Date: _____

If not signed by the patient, please indicate relationship:

( ) Parent or guardian of minor patient (to the extent minor could not have consented to care)
( ) Guardian or conservator of patient
( ) Beneficiary or personal representative of deceased patient
( ) Spouse or person financially responsible (where information solely for purpose of processing application for dependent health care coverage)

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AUTHORIZATIONS FOR RELEASE OF HEALTH INFORMATION

The Amended HIPAA Privacy Rule states that you must receive a Privacy Notice telling you how your personal health information will be used and disclosed. Section 164.520(c) (2) (i) (A).

1. Pain Management and Injury Relief may release your medical information to your health care providers and insurance companies.
2. Pain Management and Injury Relief may obtain your medical information from your healthcare providers and insurance companies.

Please list all family member(s)/guardian(s) that may access your medical records and/or financial and billing information. Please List ALL:

Name of Person	Relationship to Patient	Medical Only	Billing Only	Both
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

I have the right to revoke this authorization at any time. My revocation must be in writing, signed by me or my legal representative, and delivered to Pain Management and Injury Relief Attn: HIPAA Compliance Officer, via mail or in person. It will be effective only when Pain Management and Injury Relief actually receives the written revocation. The information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Printed Patient Name _____ Patient's Date of Birth _____

Signature of Patient _____ Date _____

Signature of Client/Personal Representative _____ Relationship to Patient _____

Please note, this form expires one year after signed. You will be asked to complete this form annually.

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STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing Pain Management and Injury Relief (the "Facility") as your health care provider. This statement explains how we bill our patients and their insurance plans for the services we provide.

In-Network Services

If you are a member of an insurance plan with which the Facility has a comprehensive services agreement (or is "in-network") we will bill your insurance plan for your care. We will also bill you for your in-network payment obligations, which could be in the form of a co-payment, co-insurance, and/or a deductible.

Out-of-Network Services

If you are a member of an insurance plan with which the Facility does not have a comprehensive services agreement (or is "out-of-network"), we will ask you to sign a Communication and Election form like the one attached as Exhibit A to this statement. The form makes clear that you understand your treatment options and financial obligations, and have chosen to seek treatment at the Facility.

It is possible that your insurance does not provide coverage for out-of-network care, including the services the Facility will provide to you. In that event, the Facility will bill you, and you will be responsible for, the full cost of the services we provide you.

It is also quite possible that your insurance does provide coverage for out-of-network care, including the services the Facility will provide to you. In that event, we will bill you for your patient share responsibilities, but will absorb the cost of any out-of-network penalties your insurer may impose and bill you based on your in-network level benefits only. That means we will seek payment from you for your in-network level co-payment, co-insurance, and/or deductible, if any. We will seek primary payment from your insurer. Like the discounted fee we charge you, we will charge your insurance company a discounted fee as well. If for some reason your insurer does not pay the discounted fee it owes to the Facility, you will be responsible for that fee, in addition to your own financial responsibility portion.

We customarily expect payment at the time we render services. If you have any questions regarding our billing procedures, please do not hesitate to contact a member of the Facility's billing staff.

Signature: _____ Date: _____

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OUT OF NETWORK

Communication & Election

I, _____, understand that Pain Management and Injury Relief is an OUT OF NETWORK Facility. I understand that I am responsible for any deductibles and or copay's associated with my Insurance Plan. I was informed prior to my procedure that I could consult with the billing department to answer any and all questions or concerns that I may have about my financial obligation with my procedure.

I wish to exercise my option to use my OUT OF NETWORK benefits and fully understand my financial obligation. I have chosen to use Pain Management and Injury Relief to have my procedure/treatment performed. I have been provided with a copy of the Pain Management and Injury Relief Patient Financial Policy, and I understand that I will be financially responsible for my co-insurance and deductibles.

"Your insurance carrier may send payment directly to you. Once you receive the check, you must turn over the check and the explanation of benefits to the surgery center within 5 business days."

_____
Print Name

_____ _____
Patient Signature Date

Name: MR#: Date:

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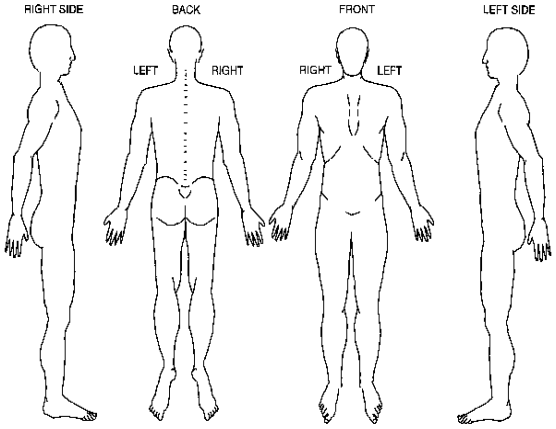
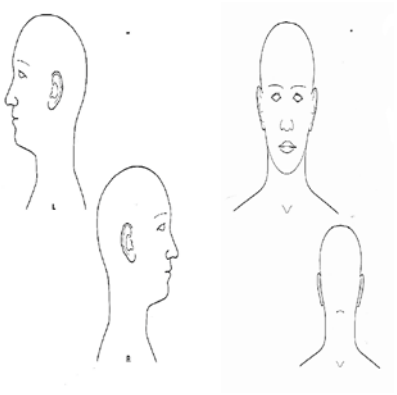
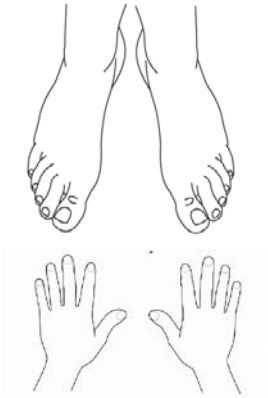
PATIENT QUESTIONNAIRE

Patient Name: _____ Date: _____
Age: _____ DOB: _____ Sex: □ Male □ Female
Who referred you to our office? (*Full Name*)_____
Where is your pain? _____
Why do you need to see a Pain Specialist?
_____

Please Mark an "X" on the figure below where your pain starts and show where it goes using an arrow: →







How and when did your pain begin? _____ (Month/Year)

□ Work Accident
□ Home Accident
□ Auto Accident
□ Other _____
□ Following Surgery/Illness
□ Other Accident
□ Unknown

Describe the circumstances around the onset of your pain:
_____
_____
_____

What is the average pain level? _____

What is the quality of your pain?

□ Sharp □ Dull □ Aching □ Burning □ Stinging
□ Throbbing □ Stabbing □ Pressure-like □ Shooting □ Numbness

How often does the pain occur?

□ Continuously □ Intermittent □ Mostly during the day □ Mostly nocturnal (at night)

How do the following factors affect your pain? (*Please √ only items that worsen or improve your pain*)

	Better	Worse
1. Weight Bearing	□	□
2. Use of Extremity	□	□
3. Lifting	□	□
4. Bending	□	□
5. Twisting	□	□
6. Standing	□	□
7. Sitting	□	□
8. Rest	□	□
9. Ice	□	□
10. Heat	□	□
11. NSAIDs	□	□
12. Non-Opioid Analgesics	□	□
13. Topic Agents	□	□

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Does any of the action listed below make your pain WORSE? (√)
□ Defecation □ Sexual Intercourse □ Sneezing □ Coughing
□ Other_____

Are there any other symptoms/problems associated with pain?
□ Difficulty Sleeping □ Feeling "blue" all the time
□ Other (please describe)
_____

Have you ever received a Durable Medical Equipment (back brace, neck brace, wrist brace, knee brace, etc.) **using your Medicare benefits**? □ Yes □ No
If yes, what type of brace? _____
When did you receive the brace? _____
Who was it purchased/rented from? _____
Are you currently using the brace? □ Yes □ No

TREATMENT HISTORY

If you do not have back or low back pain, skip this section and go to "past medical history" section)

Which of the following caregivers have you visited prior to your arrival here? (*Please provide names*)
_____
□ Family Physicians (includes general practitioners, Internists, gynecologists, etc.)
□ Orthopedic Surgeon □ Neurologist □ Rheumatologist □ Chiropractor
□ Acupuncturist □ Physical Therapy □ Other Pain Management _____

Which of the following test(s) have you undergone prior to your arrival today?
□ X-Rays □ CAT Scan □ MRI Scan □ EMG test
□ Discogram □ Neural Block □ Myelogram

Have you had any of the following interventions done for your neck or low back pain?
□ Trigger Point Injections □ Ultrasound □ Heat □ Cold □ Cryotherapy
□ TENS/ nerve stimulator □ Discography □ Facet □ Sacroiliac □ Other Joint injections _____

Have you ever had any of the following surgical interventions (for neck and back pain)?
□ Back Surgery: fusion Date: _____
□ Back Surgery: non-fusion Date: _____
□ Back Surgery: Spinal Cord Stimulator Date: _____

List all Surgeries and their DATES:
_____
_____
_____

PATIENT HISTORY

Please list all, if any DRUG ALLERGIES and their REACTIONS:
_____
_____

Do you take any of the following?
□ Aspirin □ Coumadin □ Plavix □ Heparin □ Pletal □ Lovenox □ Ticlid □ Effient

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Please list all MEDICATIONS

CURRENT MEDICATIONS	DOSAGE	HOW OFTEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

SOCIAL HISTORY

Any use to Tobacco (type and for how long)?

_____

Any use of Alcohol (type and for how long)?

_____

Any use of Recreational Drugs (type and for how long)?

_____

What type of work do you do? _____

Marital Status: □ Single □ Married □ Divorced □ Widowed

PAST MEDICAL HISTORY

Do you now or have you ever had:

□ Diabetes
□ High Blood Pressure
□ High Cholesterol
□ Hypothyroidism
□ Goiter
□ Cancer (type) _____
□ Leukemia
□ Psoriasis
□ Pneumonia
□ Pulmonary Embolism
□ Asthma
□ Emphysema
□ Stroke
□ Epilepsy (seizures)
□ Angina
□ Heart Problems
□ Jaundice
□ Stomach or Peptic Ulcer
□ HIV/AIDS
□ Kidney Disease
□ Colitis
□ Anemia
□ Hepatitis

Other Medical Conditions (Please list):

_____

_____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age(s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Sibling(s)				
Children				

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REVIEW OF SYMPTOMS

If you <u>currently</u> have any of the following Symptoms, please place a (√) on the one that applies:

General
□ Fatigue
□ Fever
□ Weight Loss

Skin
□ Numbness
□ Tingling
□ Bruising
□ Discoloration
□ Hair loss
□ Nail Changes
□ Sweating Changes
□ Rash

Eye/Ear/Nose/Throat
□ Blurred Vision
□ Double Vision
□ Loss of Vision
□ Eye Pain
□ Eye Redness
□ Eye Dryness
□ Decreased Night Vision
□ Trouble Hearing
□ Loss of Hearing
□ Ringing in the Ears
□ Dizziness (vertigo)
□ Loss of Balance
□ Ear Pain
□ Ear Discharge
□ Sleep Apnea

Neck
□ Neck Pain
□ Swollen Glands

Respiratory
□ Asthma
□ Chronic Cough
□ Difficulty Breathing

Cardiovascular
□ Chest Pain
□ Irregular Heart Beat
□ High Blood Pressure
□ Limb Pain on Walking
□ Fainting
□ Calf Cramps
□ Heart Disease
□ Edema
□ Hypertension
□ Leg Pain and/or Swelling
□ Palpitations
□ Shortness of Breath
□ Slow Heart Rate

Stomach & Intestines
□ Indigestion
□ Heartburn
□ Abdominal Pain
□ Nausea
□ Vomiting
□ Regurgitation
□ Diarrhea
□ Constipation

Kidney/Urine/Bladder
□ Incontinence
□ Pain on Urination
□ Blood in Urine
□ Testicular Pain

Muscle/Joints/Bones
□ Leg Cramps
□ Muscle Pain
□ Muscle Twitches
□ Loss of Muscle Bulk
□ Neck Pain
□ Back Pain
□ Joint Pain
□ Joint Stiffness
□ Joint Swelling
□ Muscle Cramps
□ Muscle Weakness

Nervous System
□ Headaches
□ Face Pain
□ Face Numbness
□ Black Outs
□ Weakness
□ Tremors
□ Seizures
□ Trouble with Memory
□ Trouble Concentrating
□ Dizziness
□ Fainting
□ Numbness
□ Stroke
□ Tremor
□ Trouble Walking

Psychiatric
□ Hallucinations
□ Feeling Depressed
□ Trouble Sleeping
□ Suicidal Ideation
□ Inappropriate Crying
□ Inappropriate Laughing
□ Anxiety
□ Insomnia
□ Panic Attacks

Endocrine
□ Excessive Rash
□ Heat Intolerance
□ Cold Intolerance
□ Excessive Urination
□ Thyroid Problems
□ Diabetes

Blood
□ Abnormal Bleeding
□ Lumps
□ Swelling
□ Easy Bruising

Signature _____ □ Patient □ Parent/Guardian □ Representative

Name: MR#: Date:

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Please list all physicians involved in your care:

Physician Name:	Specialty:	
Address:	City:	State/Zip:
Phone:	Fax:	

Physician Name:	Specialty:	
Address:	City:	State/Zip:
Phone:	Fax:	

Physician Name:	Specialty:	
Address:	City:	State/Zip:
Phone:	Fax:	

Physician Name:	Specialty:	
Address:	City:	State/Zip:
Phone:	Fax:	

Physician Name:	Specialty:	
Address:	City:	State/Zip:
Phone:	Fax:	

Patient Name: **Date: _____**

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Long –Term Controlled Substances Therapy for Chronic Pain Agreement

(A consent form from the American Academy of Pain Medicine)

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long –term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long – term benefits. There is also the risk of an addictive disorder developing or of a relapse occurring in a person with a prior addiction. The extent of this risk is uncertain.

Because patient use of these drugs has potential for abuse or diversion, strict accountability is necessary when patient use is prolonged. When the doctor, whose signature appears at the last page, is willing to consider the initial and/or continued prescription of controlled substances to treat your chronic pain, this agreement will only be subject to your strict adherence to the following policies indicated below:

All controlled substances must come from the physician (whose signature appears on the last page), or during his/her absence, by the covering physician, unless specific authorization is obtained for an exception. Multiple sources can lead toward (*unfavorable*) drug interactions or poor coordination of treatment.

All Controlled Substances must be obtained at the **same pharmacy** when possible. Should the need arise to change pharmacies, our office must be informed. Please indicate below, the pharmacy or pharmacies you have selected.

_____ Phone_____

_____ Phone_____

You are expected to inform our office of any new medications or medical conditions, and of any adverse (*unfavorable*) effects you experience from any of the medications that you take.

The prescribing physician has permission to discuss all diagnostic and treatment details with the dispensing pharmacists or other professional who provide your healthcare for purposes of maintaining accountability.

Please be aware that Pain Management and Injury Relief Medical Center will transmit your prescriptions electronically to the pharmacy that you designate as your primary pharmacy provider. Additionally, Pain Management and Injury Relief Medical Center will obtain your prescription history for the past two years from pharmacy benefit managers. Your prescription history will be maintained as a part of your electronic health record.

You may **NOT SHARE**, **SELL** or otherwise permit others to have access to these medications.

These drugs should not be stopped abruptly, as an ***abstinence syndrome*** will likely develop.

Prescriptions and/or containers of these medications may be sought by other individuals with a chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication(s) and prescription. They should **NOT** be left out where others might see or otherwise have access to them.

Original containers of medication should be brought into the office only if requested by your doctor.

Since these drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such persons.

Medications **MAY NOT BE REPLACED** if they are lost, become wet, are destroyed, left on an airplane, etc. You must immediately file a police report preferably with the police department in the area where the medication or prescription was lost or stolen. Obtain a police report number, along with the police officers name and contact number, before your doctor can make a decision to replace the lost or stolen item.

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EARLY REFILLS will generally not be given (most controlled medications are prescribed on a 30-day basis).

Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they will not be filled prior to the appropriate date.

If the responsible legal authorities have questions concerning your treatment, as might occur, for example; if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

It is understood that failure to adhere to these policies may result in cessation of therapy with the controlled substance prescribed by this physician or referral for further specialty assessment.

Renewals are contingent on keeping scheduled appointments. **WE DO NOT phone in prescriptions after hours or on weekends.**

It should be understood that any medical treatment is initially a trial, and that the continued prescription of the medication(s) is contingent on evidence of benefit.

The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation).

I understand the risk of Opioids and sedatives including but not limited to: Nausea, Vomiting, Itching, Constipation, and Urinary retention, Respiratory, Depression, Allergic Reaction and Death.

I _____, understand and agree by signing this agreement that if requested by the
(**Patient Name**)
Doctor(s): **DR HERSEL**, or **DR SPIEGEL**,
I authorize Pain Management and Injury Relief Medical Center to perform unannounced urine or serum toxicology screens(s) if the doctor deems necessary.

I also understand my cooperation regarding this matter is required.

Pain Management and Injury Relief Medical Center enforces a zero tolerance policy of illicit drug use. Therefore, presence of an unauthorized substance(s) may prompt referral for assessment for an addictive disorder and discharge from this office.

You affirm that you have the full right and power to sign and be bound by this agreement, and that you have read, understood and accepted all of its terms.

_____ **Physician Signature**

_____ **Patient Signature**

_____ **PRINT Physician Name**

_____ **PRINT Patient Name**

Date_____

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Notice of Privacy Practices

Protected Health Information

All Patient information including but not limited to written, typed, faxed or electronic correspondence, billing, demographic and all medical records and charts will be physically and electronically protected in order to maintain patient privacy and confidentiality and to protect unauthorized access to that information.

All Physicians and staff members will implement the following policies and procedures:

1. All patient information will be maintained in the medical record chart and the chart will be kept in a lockable file cabinet with lockable doors with limited key access.
2. Medical charts, notes billing information, schedules and any other form of patient information will not be left within view of or accessible by unauthorized persons.
3. All Physician and staff confidential conversations regarding patients are to take place, to the maximum extent possible, only in areas that cannot be overheard by unauthorized persons.
4. Computer data integrity will be maintained with firewall and virus protection software, regular backups of information and by limited access with password protection by only authorized personnel.
5. Patient medical information, photographs or images will not be released without the written consent of the patient/representative or legal guardians. Release of information for research, educational or diagnostic purposes will require the patient's written authorization.
6. Patient information may be released without prior consent for purposes such as: treatment, to report abuse, neglect, domestic violence, public health risks, to obtain payment for treatment, communication with family members if necessary or to report reactions to medication or products.
7. Patient's have the right to inspect and receive a copy of their medical records and to request an amendment to their records. Although the health care provider has the right to deny inclusion of an amendment, the patient has the right to file a **"Statement of Disagreement"** which will then become part of the patient's record.

Patient's at Pain Management and Injury Relief Medical Center are provided with this notice of Privacy Practices and will be asked to sign an acknowledgment that will become part of the patient's medical records.

******Patient Copy*****

Name: MR#: Date: