All Locations: Phone (855) 918-PAIN Fax (918)742-9958

Dear Patient:

You have an appointment to see _________________________________ on __________________________. We look forward to working with you, and evaluating and treating your pain. **Please arrive at least _________ minutes early to process your paperwork. Also, please be prepared to present your <u>insurance card</u> and make <u>any applicable co-payment</u> at that time.** Your initial visit will take place at the facility marked below:

Check One

	Tulsa Pain Consultants (918) 742-7030	<u>Williams Medical Plaza Building</u> 2000 South Wheeling, Suite #600 Tulsa, OK 74104
	Muskogee Pain Consultants (918) 683-1295	<u>Honor Heights Plaza</u> 3204 W. Okmulgee Muskogee, OK 74401
	Bartlesville Pain Consultants (918) 331-9200	<u>Towne Center</u> 2334 SE Washington Bartlesville, OK 74006
	Tulsa Spine and Specialty Hospital (918) 388-5701	<u>Olympia Medical Park</u> 6901 S. Olympia Avenue Tulsa, OK 74132

INSTRUCTIONS FOR <u>PROCEDURE</u> APPOINTMENTS ONLY!

- Nothing to eat 6 hours prior to your appointment.
- No liquids of any kind 4 hours prior to your appointment
- Take your usual medication with a sip of water
- Bring a driver.
- If you are taking any of the following medication: Insulin, Glucophage, or any blood thinners (i.e. Coumadin, Plavix). please contact a member of our medical staff at (918)742-7030 option 7

FAILURE TO FOLLOW THESE INSTRUCTIONS MAY RESULT IN RESCHEDULING YOUR PROCEDURE!

A complete history of your medical background and pain issues are extremely important. Attached you will find your **New Patient Paperwork, <u>which you will need to complete using Black or Blue ink</u>**. Failure to do so will delay your appointment or possibly cause your appointment to be rescheduled. Please **bring your completed paperwork with you to your appointment.**

To promote an environment in which providers have ample time to adequately evaluate and treat all patients, we have established the following policies:

1) If you are more than 15 minutes late for your appointment, we may reschedule you for another day or time.
2) If you fail to give 24hour notice to reschedule or cancel and an appointment a 25.00 fee may be applied to your account.
3) If you are late for your appointment on three (3) occasions, we may dismiss you from our practice.
4) If you fail to show for an appointment on two (2) occasions without having called us to cancel the appointment more than 24 hours ahead of time, we may dismiss you from our practice.

Thank you for allowing the physicians and staff of Tulsa Pain Consultants to be of service to you. Should you have any questions, please feel free to contact us at (918) 742-7030 between the hours Monday through Thursday 7:45 am and 4:45 pm, Friday 7:45 am to 12:30 pm (excluding holidays).

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PATIENT REGISTRATION AND INFORMATION

Name:	Nick name/ Alias	Social Security Number:
Address:	Home Phone:	Cell Phone:
City, State & Zip Code:	Email address:	
Sex: M F	Date of Birth:	Marital Status:
Employer:	Occupation:	
Business Address:	Business Phone:	
Referring Doctor:		
Emergency Contact:	Telephone Number:	

SPOUSE INFORMATION

Name of Spouse:	Social Security Number:	Date of Birth:
Spouse's Employer:	Telephone Number:	

RESPONSIBLE PARTY

Person Responsible for Payment:		
Relationship to Patient:	Social Security Number:	Date of Birth:
Address: (if different from patient)	Telephone Number:	
City, State & Zip:		
Responsible Party Employer:	Work phone number:	Occupation:

INSURANCE INFORMATION

Primary Insurance:	Subscriber:	Date of Birth:
Billing Address:		
City, State & Zip:		
Employer / Address:	Insurance ID#	Group#:
Secondary Insurance:	Subscriber:	Date of Birth:
Billing Address:		
City, State & Zip:		
Employer / Address:	Insurance ID#	Group#:

Is your injury work related? Yes ❐ No ❐ Is your visit personal injury or MVA related? Yes ❐ No ❐

If you answered yes to the above question and are represented by an attorney, list their name, address and telephone below:

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have the above stated insurance coverage and assign directly to Tulsa Pain Consultants, Inc., P.C. all insurance benefits payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Tulsa Pain Consultants, Inc., P.C. to release any information necessary to secure payment of benefits on all insurance submissions. Further, I authorize the release of my medical records from the office to either myself, or any and all medical personnel necessary for my continued medical care. In providing this consent, I am fully aware that the physicians of Tulsa Pain Consultants, Inc., P.C., the staff, and employees cannot be responsible for the confidentiality of the information disclosed after medical records have been released; and therefore, release the physicians, staff, and employees from any liability arising from such disclosure.

Patient Signature:	Date:
Responsible Party Signature:	Date:

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PATIENT INFORMATION / HISTORY FORM

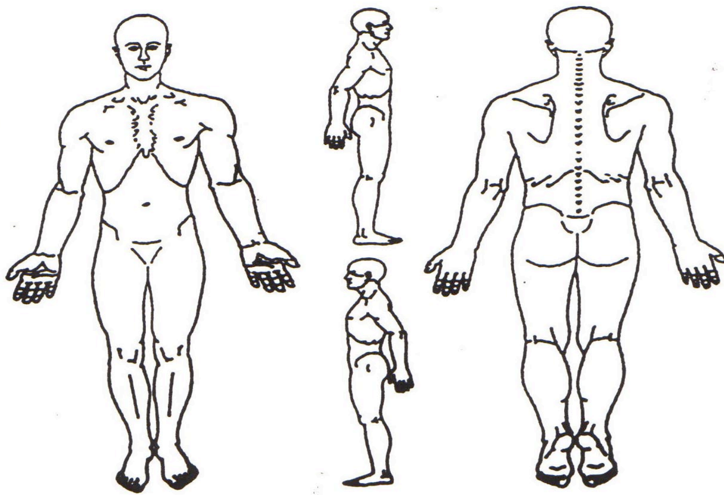
Name:____
Last First MI

Age:_______ Sex: ❒Male ❒Female Weight:________ Height: ________

Referring Physician:______________________ Primary Care Physician________________________

Please briefly describe your main problem:____

Indicate on the pictures below the area(s) of your pain. Use "X" for pain and "0" for numbness.



When did your pain start? (approximate date)____

How did your pain start? ____

Is your pain ❒constant or ❒comes and goes?

Present level of pain intensity (circle one)

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No Pain			Mild		Moderate			Severe		Excruciating

What words best describe your pain? (Circle as many as apply)

Sharp Burning Throbbing Shooting Aching Cramping Dull Crushing

Stabbing Tingling Coldness Hotness Electricity

Other____

____

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Patient Name________________________

What brings on the pain or makes it worse? (Circle as many as apply)

Sitting Standing Walking Twisting Lifting Sneezing Coughing Using arms
Bending forward Bending backward Other ____

What eases or eliminates the pain? (Circle as many as apply)

Lying down Standing Exercise Arthritis Medicine Pain Pills
Muscle relaxants Nothing Other ____

Do you have any loss of control of your bowels or bladder? ❒Y ❒N
Do you have pain that shoots down your arms or legs? ❒Y ❒N
Do you have any increasing weakness in your arms or legs? ❒Y ❒N

Please circle all the following medical problems that you have had (circle as many as apply):

Heart problems Heart Attack High Blood Pressure Stroke Blood clots Diabetes
Asthma Kidney Failure Kidney Infections Liver Problems Thyroid Problems COPD
Lung Problems Depression Headaches Glaucoma Seizures Ulcers Hepatitis A/B/C
Immune Disorder Sleep Apnea (with CPAP) HIV Cancer________ Other ____________

Please list all past surgeries you have had:

Year:______/________________________________ Year:______/________________________________

Year:______/________________________________ Year:______/________________________________

Year:______/________________________________ Year:______/________________________________

Year:______/________________________________ Year:______/________________________________

Please list all current prescription medications and herbal supplements, vitamins, topical creams and over the counter medications:

Medication	Dose	Frequency	Route
(Example) Lortab	**10mg**	**3 times a day**	**Oral, iv, topical**

Do you have any medication ALLERGIES? No: Yes, list Medications:

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Patient Name_________________________

Please list any pain medications you have tried ***in the past***: ________________________________
____
____

Do you take any of the following medications: (please circle any that apply)
Coumadin, Aspirin, Plavix, Lovenox, or Heparin

` Please indicate which **tests** you have had to evaluate your present pain (with date):

MRI_______________ CT Scan_______________ Myelogram___________________
Bone scan _________ Discogram _____________ EMG_________________________
Other:____
Please list any procedures you have received for your pain (with date and doctor)
____

Please list any other treatments you have received for pain(TENS, chiropractic, physical therapy, biofeedback)____

Work history:

What is/was your occupation?____
❒Work full time ❒Work part-time ❒Unemployed ❒Homemaker
❒Retired ❒On Disability ❒Other _________________________________
When did you last work? ____
If your pain is work related, what was the date of your injury?_________________________
Do you currently have an attorney in regards to your pain condition? ❒Y ❒N
If yes, please provide name and phone number. _____________________________________

Social history:

Are you: ❒Single ❒Married ❒Separated ❒Divorced ❒Widow
Do you have children? ____________________ How many? ___________________________
Who lives in your home with you? ____
Do you smoke? ❒Y ❒N If yes, how many packs of cigarettes per day?________________
Are you a former smoker?❒Yes ❒No If yes, when did you quit? __________________
Do you drink alcohol?__________ If yes, how much in a week?____________________
Do you have a history of alcohol, street drugs, or prescription medicine abuse? ❒Y ❒N
Have you ever been arrested or convicted on a drug related charge? ❒Y ❒N
If yes, please explain and provide dates____

Sleep and mood:

How many hours a night do you sleep? ____
Have you ever been diagnosed with depression, psychosis, schizophrenia, or bipolar disorder?
If yes, which one(s)?____
Are you seeing a psychiatrist or psychologist? ❒Y ❒N For what?___________________
Do you have any thoughts of hurting yourself or others? ❒Y ❒N
If yes, please explain: ____

PHQ 9 Total Score:_______________

Date of your last flu shot: ________________________________
If you are 65 or older have you ever had a pneumococcal vaccine (Pneumonia shot)? ❒Yes ❒No

Do you have a care plan? ❒Living will ❒DNR (do not resuscitate) ❒Do not want to discuss

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HEALTH QUESTIONNAIRE (PHQ-9)

Name: ________________________________ Date: ___________________________________

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "√" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
7.Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- Being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Add columns	+		+
Total:			

(healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card)

10. If you checked off any problems, how difficult	Not difficult at all	_________
have these problems made it for you to do	Somewhat difficult	_________
your work, take care of things at home, or get	Very difficult	_________
along with other people?	Extremely difficult	_________

Patient Name:________________

Family history:	**Please check all that apply:**
Alcoholism	❒Mother ❒Father
Substance abuse	❒Mother ❒Father
Cancer	❒Mother ❒Father
Stroke	❒Mother ❒Father
Depression	❒Mother ❒Father
Mental illness	❒Mother ❒Father
Heart problems	❒Mother ❒Father
Other___________________________	❒Mother ❒Father

Please provide us with any additional information that you feel would assist us in treating your pain____

Please circle if any of these apply to you: **Pregnant: ❒Y ❒N**

General: Fever, weight loss, weight gain, poor appetite, sexual problems, insomnia

Neurological: Headache, seizures, paralysis, confusion, disorientation, numbness, tingling

Eye, Ear, Nose, Throat: Blurry vision, trouble swallowing, loss of hearing, voice changes,

Respiratory: Emphysema, bronchitis, asthma, tuberculosis, shortness of breath

Cardiovascular: Chest pain, abnormal heart beats, heart failure, heart murmurs

Gastrointestinal: Nausea, vomiting, hepatitis, pancreatitis, blood in stool, constipation

GU: Blood in urine, recurrent urinary infections, kidney stones, trouble urinating

Musculoskeletal: rheumatoid arthritis, lupus erythematosis

Skin: Rash, open sores, recurrent infections, tumors, skin cancer

Endocrine: Diabetes, thyroid problems, adrenal dysfunction, pituitary problems

Hematologic: Leukemia, lymphoma, anemia, bleeding gums

Other: ____
____

The doctors and staff thank you for taking the time to complete this questionnaire. The information that you have provided us will be beneficial as we work to manage your pain; and as always, all the information given is held in the strictest of confidence.

Notes:

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MEDICATION POLICY

We are here to provide you with the best quality treatment of your pain. To do this, we have prepared the following policies to ensure your safety, and our continued ability to treat you in the most effective way possible. Please read this carefully. These policies are for your protection, ***and will be enforced.*** You will be asked to sign a contract stating that you promise to follow these terms.

1. **Medication must be taken only as prescribed by our physicians and you must not take pain medication given to you by another person or physician. If you are given a prescription by another doctor's office: please notify our office immediately.**
2. Medication is prescribed to increase your function so that you can work, participate in physical therapy, exercise programs, and weight loss programs. If your activity level does not improve with medication, alternative methods of pain management may be substituted for medication.
3. Any medication that is lost, misplaced, stolen, destroyed, or finished early **will not be replaced for any reason.**
4. You must not share, sell, or otherwise permit others to have access to these medications.
5. All prescriptions should be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed.
6. The prescribing physician and staff have permission to discuss diagnostic and treatment details with dispensing pharmacists or other professionals who provide your healthcare for the purpose of medication accountability. We retain the right to discuss your treatment with law enforcement officials during any official investigation.
7. **Refills will be given only during office hours.**
8. We require at least **5 business** days notice to refill your prescriptions. The telephone number(s) to our prescription refill line at each site are as follows: **Tulsa Pain (918-745-6200), Muskogee Pain** (**918-687-7371),** and **Bartlesville Pain (918-333-3854)**. It is your responsibility to monitor your medications and request a refill in a timely fashion. Prescriptions called in on Friday cannot be refilled until the following Tuesday. Any prescriptions that need to be mailed require 10 business days notice.
9. You must keep your scheduled appointments. If you fail to appear for an appointment, your medication may not be refilled and you may be required to pay $25.00 no show fee. If you fail to appear for more than 2 appointments, you may be dismissed from our practice
10. You must provide us with 48 hours notice to cancel an appointment. If you fail to provide this notice, your appointment will be considered as a failure to appear and may be subject to the fee and limitation of refills described above.
11. A random urine drug screen may be requested and sent to toxicology laboratory for testing. Presence of unauthorized substances or abnormal results may result in discontinuation of your controlled medications including, but not limited to opioids.
12. You must sign a contract indicating that you acknowledge and understand the Medication Policy of Tulsa Pain Consultants, Inc.
13. You must be seen in our office as often as deemed necessary for medication maintenance purposes.

Your health care pain management team is dedicated to your safety and control of your pain, but we must have your cooperation to achieve these goals. This Medication Policy is designed to ensure your safety and to help us and you comply with the standards of good medical care, as well as state and federal narcotics laws.

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FINANCIAL POLICY

FULL PAYMENT OF OFFICE COPAYS IS DUE AT TIME OF SERVICE. You are responsible for deductibles and coinsurance as directed by your insurance policy. We accept cash, checks, Visa/Mastercard, Discover and American Express.

Insurance
Your office copay is due at the time of your visit. For your convenience, we will file insurance claims with all insurance carriers. You will be responsible for any deductibles and coinsurance as explained in your policy. We cannot bill your insurance company unless you provide us with all insurance information, so please bring your insurance cards to your appointment. You are responsible for notifying us of any changes in insurance coverage each visit. If no insurance card is presented at the time of service, you will be treated as a cash patient and will need to pay for services as they are rendered. Once the card is presented within our insurance contract guidelines for billing claims, we will gladly file a claim and refund any money due back to you after claims have been processed and we receive payment from insurance.

Out-of-Network or Non-Covered Services
If patient is out of network due to our doctor(s) not yet contracted but is in processing, we will consider patient as in net work and will use in network rates to balance bill patients. Patients will only be responsible for balance at in network rate .Charges not covered by your carrier with signed ABN will be required to pay such amounts due when billed.

Private Pay
If you do not have insurance, payment is due at time of service. We accept cash and credit cards. Please be prepared to pay in full at the time of your visit unless prior payment arrangements have been made.

Worker's Compensation
Only authorized referrals will be accepted. If notification is not received prior to the appointment, the patient will be responsible for charges incurred. Patient must notify Tulsa Pain Consultants prior to their scheduled appointment with the following information: attorney's name and phone number; employer name, contact person and phone number; work comp carrier name, adjustors name and phone number; the date of injury, and claim number. Any court order must be brought in at time of visit.

Personal Injuries/ MVA
Payment is expected at time of service. We will file private insurance provided you have subrogated with your insurance company. The patient is responsible for all copays and they are due at time of service. Deductible and/or coinsurance are the patient's responsibility and are required to be paid when billed. We will accept Med-Pay if available provided said Med-Pay will issue direct payment to Tulsa Pain Consultants.

Returned/Insufficient Checks
If we receive your check back from the bank for insufficient funds/account closed, you will receive a $25 charge to your account and we will no longer accepts **any** checks for your account. You may pay on your account by cash, credit card or money order.

Testing:
Testing done in our office, such as urine drug screens, may be sent to an outside toxicology laboratory for additional testing. You may receive an additional bill from this laboratory. If you have any questions regarding these bills, please contact the laboratory directly for billing questions.

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NOTICE OF PRIVACY PRACTICES

Effective date April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Tulsa Pain Consultants (including its family of clinics) is committed to protecting your medical information. This Notice describes your rights and our legal duties regarding your protected health information. We create and maintain, on a variety of media, including paper, computers and films, a record of the care and services you receive. This information is available to all Office Practice employees, and physicians, who need this information to provide treatment to you, to obtain payment for services rendered to you or to support health care operations necessary for the operational aspects of your care. We are required by law to:

- Have proper safeguards in place to discourage improper use or access.
- Protect the privacy and confidentiality of your personal and protected health information and records.
- Describe your rights and our legal duties regarding your protected health information.

WHAT DO THESE WORDS MEAN?

Protected Health Information (PHI)
Your personal and protected health information created and used by us to provide care to you and bill for services provided.

Privacy Officer
The person responsible for the policies and procedures developed to protect your PHI and for investigating your complaints on how your PHI is used or disclosed.

Business Associate
An independent business or individual who contracts with the Office Practice for services provided to you or the Office Practice.

Authorization
A document signed by you that gives us permission to use or disclose your protected health information for purposes other than your treatment, obtaining payment for your treatment or our health care operations.

WHAT WILL YOU DO WITH MY MEDICAL AND BILLING INFORMATION?

The following categories describe how we may use and disclose your protected health information. Not every use or disclosure in a category will be listed. To ensure compliance with Oklahoma law, we will obtain your consent for the use and disclosure of your protected health information. **INFORMATION USED AND DISCLOSED MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE AND MAY INCLUDE, BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNO-DEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).** If you do not consent, we cannot provide you treatment except in emergency situations or when we cannot communicate with you for some other reason.

1. Treatment: We may *use* your protected health information to provide you with medical treatment or services. We may *disclose* your protected health information to doctors, nurses, technicians, medical students, or other Office Practice personnel who are involved in your care.

Example:

- The surgeon treating your broken leg may need to know if you have diabetes because diabetes may slow the healing process.
- The doctor treating you for high blood pressure may ask a nurse to take your blood pressure and report this to the doctor.

We also may disclose your medication information to other medical personnel outside the office practice that will provide medical treatment or services.

Example:

- The treating doctor may send a sample of your blood to be tested at a lab and inform the lab of your condition and a brief medical history so the lab will know what tests to run.

2. Payment: We may *use* and *disclose* your protected health information so that the treatment and services you receive may be billed to and payment collected from you, your insurance company or a third party.

Examples:

- We may need to give your health plan copies of your physician’s chart notes about the treatment you received in the office for high blood pressure so your health plan will pay us or reimburse you for the treatment.
- We may also tell your health plan about a blood pressure treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

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NOTICE OF PRIVACY PRACTICES

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3. Health Care Operations: We may *use* or *disclose* your protected health information for Office Practice operations. These uses and disclosures are needed to run the Office Practice and make sure that all our patients receive quality care.
Examples:
- We may use your blood pressure measurements to review our treatment and services and evaluate the performance of our staff in caring for you.
- We may also combine medical information about many office patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective.
- We may also combine medical information we have with medical information from other offices to compare how we are doing and see where we can make improvements in the care and services we offer.

4. Business Associates: We may *disclose* your protected health information to Business Associates independent of the Office Practice and with whom we contract to provide services on our behalf. We will only make these disclosures after receiving satisfactory assurances that the Business Associate will properly safeguard your privacy and the confidentiality of your protected health information.
Examples:
- We may contract with a company outside of the Office Practice to provide medical transcription services for the Office Practice or to provide collection services for past due accounts.

5. Appointment Reminders: We may *use* and *disclose* your protected health information to contact you as a reminder that you have an appointment for treatment or medical care. This may be done through an automated system or by one of our staff members to your landline or wireless cell phone. If you are not at home, we may leave this information on your answering machine, voice mail or in a message left with the person answering the telephone.
6. Health Related Benefits and Services: We may *use* and *disclose* your protected health information to tell you about health-related benefits or services to recommend possible treatment options or alternatives that may be of interest to you.
7. Marketing: We may *disclose* certain protected health information to a third party to provide marketing materials and information to you.
8. Facility Directory: We may release your name and general condition to people who ask for you by name so your family and friends can know generally how you are doing. *If you do not want to be included in this directory,* notify Office Practice personnel during registration.
9. Individuals Involved in Your Care or Payment for Your Care: We may release protected health information to a friend or family member who is involved in your medical care. We may also give protected health information to someone who helps pay for your care. We may *disclose* protected health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
10. Research: Under certain circumstances, we may *use* and *disclose* your protected health information for research purposes or, to determine whether you might benefit from, or be willing to be involved in certain research.
Examples:
- A research project may involve comparing the health and recovery of all patients with high blood pressure who received one blood pressure medication to those who received another type of blood pressure medication to determine which type is most effective.
- We may disclose your protected health information to people preparing to conduct a research project so long as the protected health information they review does not leave the office.

Most research only uses medical information without using your name, address or other information that reveals who you are. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are or if your medical information will leave the office.

CAN YOU EVER USE OR DISCLOSE MY PROTECTED HEALTH INFORMATION WITHOUT MY CONSENT?
Yes. The following categories describe ways we may use or disclose your protected health information without your consent. Not every use or disclosure in a category will be listed.
1. Required by Law: We will *disclose* your protected halth information when required to do so by federal, state or local law.
Example:
- Oklahoma law requires us to report all communicable or venereal diseases which are identified or diagnosed in our office to the Oklahoma State Department of Health.

2. To Avert a Serious Threat to Health or Safety: We may *use* and *disclose* your protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. This disclosure would only be made to someone able to help prevent the threat.
3. Organ and Tissue Donations: If you are an organ donor, we may release your protected health information to organizations that handle organ procurement for organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

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4. Military: If you are a member of the Armed Forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.
5. Workers Compensation: We may release your protected health information for workers compensation or similar programs as authorized by State laws. The programs provide benefits for work related injuries or illness.
6. Public Health Reporting: We may *disclose* your protected heath information for public health activities. *Examples:*

- Prevention or control of disease, injury or disability.eporting of birth defect or infant eye infection.
- Reporting of cancer diagnoses and tumors.
- Reporting of reactions to medication or problems with products.
- Notification of people using products that are recalled.
- Notification of the Oklahoma State Department of Health about people who may have been exposed to a disease or at risk for contracting or spreading a disease or condition such as HIV, Syphilis or other sexually transmitted diseases.
- Reporting of abuse, neglect or violence as required by law, including children who are born with alcohol or other substances in their body.
- Reporting of births and deaths.

7. Health Oversight Agencies: We may *disclose* protected health information to a health oversight agency for activities necessary for the government to monitor the health care system, government programs, and compliance with applicable laws. These oversight activities include, for example, audits, investigations, inspections, medical device reporting and licensure.
8. Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may *disclose* your protected health information in response to a court or administrative order. We may also *disclose* your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
9. Law Enforcement: We may release protected health information if asked to do so by a law enforcement official.
Examples:

- In response to a court order, subpoena, warrant summons or similar process.
- To identify or locate a suspect, fugitive, material witness or missing person.
- About a crime victim if, under certain circumstances, we cannot obtain your agreement.
- About a death we believe may be the result of criminal conduct.
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

10. Coroners, Medical Examiners and Funeral Directors: We may *disclose* protected health information to a coroner, medical examiner or funeral director.
Examples:

- To identify a deceased person or determine the cause of death.
- To assist the funeral director in completing the death certificate.

11. National Security and Intelligence Activities: We may *disclose* your protected health information to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.
12. Protective services for the President and Others: We may *disclose* your protected health information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
13. Inmates: If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may *disclose* your protected health information to the correctional facility or law enforcement official. This may be necessary (1) for the correctional institution to provide you with health care or (2) to protect the health and safety of yourself, others or the correctional institution.

WHAT ARE MY RIGHTS REGARDING MY PROTECTED HEALTH INFORMATION?
You have the following rights regarding your protected health information that we maintain about you. *You are required to submit a written request to exercise any of these rights for records we create and maintain.*
1. Right to Inspect and Copy: You have the right to inspect and request a copy of your protected health information, except as prohibited by law. If you request a copy of your protected health information, we may charge 25 cents per page. We may deny your request to inspect and copy in certain circumstances, such as a request for mental health records. If you are denied access to certain protected health information, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

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NOTICE OF PRIVACY PRACTICES

Effective date April 14, 2003

2. Right to Amend: If you feel that the protected health information created by us is incomplete or incorrect, you may request an amendment for as long as we maintain the information. You must provide a reason that supports your amendment request. If your request is not in writing or does not include a reason to support your request for amendment, we may deny your request for amendment. We may also deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the protected health information maintained by us.
- Is not part of the information that you would be permitted to inspect or copy.
- Is accurate and complete.

3. Right to an Accounting of Disclosure: You have the right to request one free 'accounting of disclosures' every 12 months. This accounting does not include disclosures made for treatment, payment or healthcare operations. Your request must state a time period which may not be longer than 6 years or include dates before April 14, 2003. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any charges are incurred.

4. Right to Request Restrictions: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request or limit the protected health information we disclose about you to a family member or friend.

Example:

- You ask us not to use or disclose information about your surgery.

We are not required to agree with your request. If we do not agree, we will comply with your request unless the information is needed to provide you with emergency treatment or the use or disclosure is required by law.

Your request must include:

- What information you want restricted.
- The type of restriction you want, and
- To whom you want the restriction to apply.

5. Right to Request Confidential Communications: You have the right to request that we communicate with you about your protected health information in a certain way or certain location.

Examples:

- You request we only contact you via mail or at your work phone number.

We will not ask you the reason for the request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

6. Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy, contact our Privacy Officer.

CAN YOU CHANGE THIS NOTICE?

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for your protected health information we already have about you as well as for any protected health information we receive in the future. Each notice will have an effective date. Copies of the current notice will be posted. Additionally, at each visit for treatment or health care services, we will make available to you a copy of the current notice.

WHAT IF YOU WANT TO USE OR DISCLOSE MY PROTECTED HEALTH INFORMATION FOR A PURPOSE NOT DESCRIBED IN THIS NOTICE?

Other uses and disclosures not covered by this notice or the laws that apply to us will only be made with your written authorization. In other words, the consent you already provided us will not be enough to use or disclose your protected health information for any purpose not described in this notice. If you provide us authorization to use or disclose your protected health information, you may revoke that authorization, we will no longer use or disclose your protected health information for the reasons covered by your authorization. You understand that we are unable to take back any uses or disclosures we have already made with your authorization.

WHAT IF I HAVE QUESTIONS OR NEED TO REPORT A PROBLEM?

If you believe your privacy rights have been violated, you may file a written complaint with us or the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

To file a complaint with us, contact our Privacy Officer at: Tulsa Pain Consultants, 2000 S. Wheeling Avenue, Ste 600, Tulsa, Oklahoma 74104

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INFORMED CONSENT AND CONTRACT FOR THE USE OF NARCOTIC MEDICATIONS AND OTHER PAIN MEDICATIONS

Our goal is to provide the best pain care possible. To accomplish this goal, we have prepared this consent and contract to explain how certain medications are used, to describe possible side effects, and to set forth your responsibilities with regard to these medications. Please read all this information carefully. Ask the physicians or clinical staff any questions you may have. Once you understand all of this information fully, please sign and date below, indicating your consent to treatment and agreement to follow the terms of this form.

I am voluntarily requesting the physicians and staff at Tulsa Pain Consultants to treat my condition of chronic pain with appropriate medications and other interventions. I understand that some medications can be addictive and/ or dangerous if misused, and that the following information is provided to ensure my safety.

I have received and agree to the terms of the **Medication Policy of Tulsa Pain Consultants (including their affiliates).**

I understand that the physicians and staff at Tulsa Pain have relied on the information I have provided in writing and verbally to select appropriate medications, and I promise that this information is complete and accurate. I understand that intentionally providing misleading information will be grounds for discharge from the practice. I understand the continued use, reduced use, or discontinuation of any pain medication is at the discretion of the physicians at Tulsa Pain Consultants and their affiliates.

PAIN MEDICATION CAN BE ADDICTIVE. This includes opioid analgesics (narcotic medicines) as well as other types of pain medication. This means my body may begin to depend on the medication, and I may experience WITHDRAWAL (unpleasant sensations) such as nausea, shakes, sweating, rapid heart rate, diarrhea, high blood pressure, pain or severe nervousness if I suddenly stop taking the medication. I understand that it is my responsibility to request refills of medications on a timely basis, and I understand that **narcotic medication will not be refilled early under any circumstance.**

To ensure my safety, I agree to take pain medications only as prescribed by the Tulsa Pain physicians, including their affiliates, and agree that I will not take pain medications given by any other physicians. I understand that taking more medication than prescribed, or taking pain medication from another source may lead to **overdose**, and this could result in slowed or stopped breathing, brain injury from lack of oxygen, coma or death.

(Please continue on to next page)

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I understand that the use of pain medications may also be associated with additional risks such as: decreased effectiveness, physical dependence, confusion, itching, difficulty urinating, allergic reactions, decreased sex drive, drowsiness, nausea, vomiting, addiction, constipation, trouble driving or operating machinery, and interaction with other medicines.

I understand that I will be subject to a urine drug screen and criminal background check if deemed necessary by my treating physician.

I understand my urine drug screen may be sent to a toxicology laboratory for testing.

I understand that I should never combine alcohol, illicit drugs such as marijuana, cocaine, heroin, methamphetamine or other illegal drugs with prescription medications, as these combinations are highly dangerous. I understand that if these substances are found in my urine or blood tests that my physician may no longer prescribe medications to me. It has been explained to me that some common toxic effects are:

- Central nervous system depression, which can range from drowsiness (at its mildest) to coma (at its most severe),
- Respiratory depression, which can lead to a person to stop breathing,
- Cardiac effects, such as changes in heart rhythm that can lead to the heart stopping,
- Decreased seizure threshold, meaning that the brain can have a seizure more easily, and/or
- Psychiatric effects, such as psychosis

After carefully reading and understanding the above terms (including those on subsequent and preceding pages), I request treatment by the physicians of Tulsa Pain Consultants and their affiliates (to include narcotic medications if appropriate), and promise to follow the terms of this contract and the Medication Policy of Tulsa Pain Consultants.

Pharmacy **Telephone Number**

Patient Name (please print) **Patient Signature** **Date**

Witness **Date**

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AUTHORIZATION AND CONSENT FOR RELEASE OF MEDICAL RECORDS

(In order for Tulsa Pain Consultants, Inc., P.C. to provide you with the best possible care, we may require copies of your medical records. For us to obtain this information, we will need your written permission. Please review the Authorization and Consent for Release of Medical Records below. Your signature on this form will allow us to obtain the necessary information.)

Being competent, eighteen (18) years of age or older and duly authorized; do willfully and voluntarily authorize the release of all medical records and information to Tulsa Pain Consultants and their affiliates.

I further understand and acknowledge the information authorized for release may include information which may be considered a communicable or venereal disease which may or may not include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, and Human Immunodeficiency Virus (HIV), also known as Acquired Immune Deficiency Syndrome or "AIDS".

____

Full Name of Patient (please print)

____

Social Security Number **Date of Birth**

____

Authorized Signature **Today's Date**

For medical records use only, please *DO NOT* complete this section.

Record Holder:______________________________ Fax Number:______________________

Tulsa Pain Consultants requests the following information at this time:

__________ All dictated reports __________ All radiology reports

__________ All anesthesia reports ____________ All therapy records

Other:____

Please fax this information to the Tulsa Pain Consultants, Inc at **(918) 742-9958**. If you are unable to fax the chart due to its size, please contact our office so that other arrangements can be made.

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Acknowledgment of Financial Policy

I acknowledge receipt and understanding of Tulsa Pain Consultant's Financial Policy.

Patient's Signature ____________________________________ Date ____________________

Patient's Name (please print) ____________________________ Date of Birth ______________

Acknowledgment of Notice of Privacy Practices

I acknowledge receipt of Tulsa Pain Consultant's Notice of Privacy Practices.

Patient's Signature ____________________________________ Date ____________________

Patient's Name (please print) ____________________________ Date of Birth ______________

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HIPAA RELEASE OF PROTECTED HEALTH INFORMATION

Please provide us with a list of names of whom you would allow our office to release

Medical Records and Prescriptions.

______________________________________ ______________
Patient or Patient's Legal Representative Printed **Date**

______________________________________ ______________
Patient or Patient's Legal Representative Signature **Date**

Information may be released to the following individual(s): **Prescriptions** **Records**

Name	Relationship to patient	Prescriptions	Records
______________	______________	❒	❒
______________	______________	❒	❒
______________	______________	❒	❒
______________	______________	❒	❒
______________	______________	❒	❒
______________	______________	❒	❒