TULSA PAIN
CONSULTANTS
Phone: (918) 742-7030 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 30 minutes early to process your paperwork and be prepared to give a urine sample if necessary. Also, please be prepared to present your insurance card and make any applicable co-payment at that time.** Your initial visit will take place at :

**Tulsa Pain Consultants**
**10810 East 45th Street, Suite 400**
**Tulsa Oklahoma, 74146**
**Phone: (918) 742-7030**

**INSTRUCTIONS FOR PROCEDURE APPOINTMENTS!**

- Do NOT eat solid food or drink dark liquids for 6 hours before your appointment time.
- You may have water, Gatorade, coffee **without** cream and fruit juice **without** pulp until 2 hours before your appointment time. (Especially if you are diabetic or have a Urine Drug Screen scheduled.)
- 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, which you will need to complete using Black or Blue ink**. 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 24 hour notice to reschedule or cancel an appointment a $30.00 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 7:20 am and 4:45 pm, Friday 7:20 am to 12:10 pm (excluding holidays).

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# Patient Education Form

During the course of your treatment with our clinic you may or may not be prescribed medications. Please review this education form for the Do's and Don'ts of taking pain medication, especially opioids.

## Do:

- Read the **Medication Guide**
- Take your medication ***exactly*** as prescribed
- Store your medication away from children and in a safe place
- Do notify us if you take anxiety medications from another provider
- Flush unused medication down the toilet or take to a take-back facility
- Call or discuss with your healthcare provider for medical advice about side effects.
- Purchase a naloxone (overdose) kit if you are instructed to do so
- Adhere at all times to the Medication Policy and Informed Consent and Patient Pain Management Agreement

## Don't:

- Do **not** give your medication to others
- Do **not** take medication unless it was prescribed for you
- Do **not** stop taking your medication without talking to your healthcare provider
- Do **not** cut, break, chew, crush, dissolve, snort, or inject your medication unless it is specifically prescribed to do so
- Do **not** drink alcohol while taking medications
- Do **not** take pain medication from another provider without notifying this office
- Do **not** take anxiety medications that are not prescribed to you

## Call 911 or your local emergency service right away if:

- You take too much medicine
- You have trouble breathing, or shortness of breath
- A child takes your medication

## Be prepared for each visit by doing the following:

- If possible, know your complete medical and family history, including any history of substance abuse or mental illness
- Bring all of your medications with you to your office visits
- Being at least thirty (30) minutes early if you are scheduled for a urine drug screen

## Be prepared to discuss the following (if applicable):

- The cause, severity, and nature of your pain
- Your treatment goals
- All the medications you take, including over-the-counter (non-prescription) medicines, vitamins, and dietary supplements.
- Any side effects you may be experiencing
- If you are pregnant or plan on becoming pregnant

For additional information on medications go to: www.dailymed.nlm.nih.gov

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## PATIENT REGISTRATION AND INFORMATION

| | | |
|---|---|---|
| Full Name: | | Nick name/ Alias |
| Address, City, State & Zip Code | | |
| Home Phone: | Cell Phone: | What number would you like Primary? ❒Home ❒Cell |
| Email address: | | |
| Sex: M F | Date of Birth: | Social Security Number |
| Race: ❒ American Indian/Alaskan Native ❒ Asian ❒ African American ❒ Native Hawaiian/Pacific Islander ❒ White | | |
| Ethnicity: ❒ Hispanic/Latin ❒ Other ❒ Decline to specify | | |
| Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Domestic Partner ❒ Other | | |
| Employer: | | Occupation: |
| Business Address: | | Business Phone: |
| Referring Doctor: | | Telephone Number: |
| Primary Provider: | | Telephone Number: |
| **Emergency Contact:** | | Telephone Number: |

## RESPONSIBLE PARTY

| | | |
|---|---|---|
| Person Responsible for Payment: | | |
| Relationship to Patient: | Social Security Number: | Date of Birth: |
| Address: (if different from patient) | | Telephone Number: |
| 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. 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

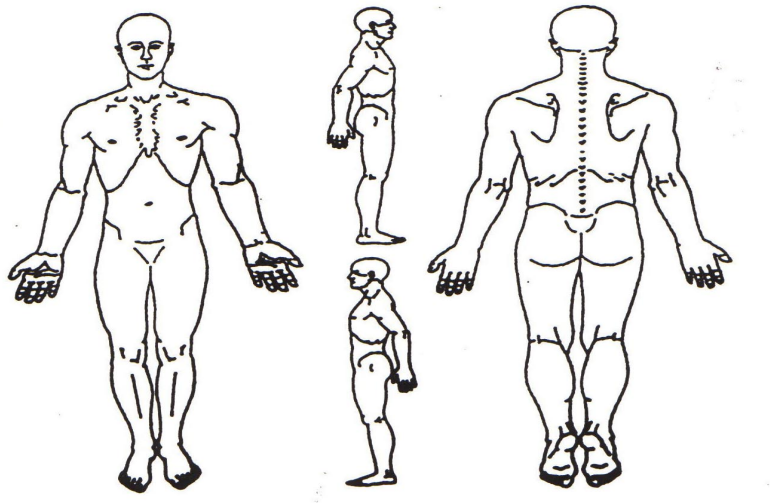
Name:_____
Last First MI

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 <u>medical problems</u> 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 <u>past surgeries</u> you have had:**

Year:_____/_____ Year:_____/_____

Year:_____/_____ Year:_____/_____

Year:_____/_____ Year:_____/_____

Year:_____/_____ Year:_____/_____

**Please list all <u>current prescription medications</u> and herbal supplements, vitamins, topical creams and over the counter medications:**

| Medication | Dose | Frequency | Route |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Do you have any medication ALLERGIES? No: ____Yes, list Medications:**_____

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**Patient Name**_____

Please list any medications (including over the counter) you have tried for pain/inflammation.

_____

**Do you take any of the following medications that are for thinning your blood or anticoagulation:**
❒Coumadin/Warfarin ❒Aspirin ❒Plavix ❒Lovenox ❒Aggrenox ❒Eliquis ❒Pletal ❒Pradaxa ❒Xarelto
**Other**:_____ **DURATION** _____ **LAST TAKEN:**_____

Please indicate which **tests** you have had to evaluate your present pain:
**Please include date and region (Cervical, Lumbar, Thoracic, Other)**
**MRI** Date_____ Region_____ **CT Scan** Date_____ Region_____
**EMG** Date_____ Region_____ **Bone Scan** Date_____ Region_____
**Discogram** Date_____ Region_____ **Other**_____ Date_____ Region_____

Please indicate which **Therapy** you have had and region (Cervical, Lumbar, Thoracic, Other):
❒Physical Therapy Effective ❒Y ❒N Date_____ to_____ ❒ Ongoing Region_____
❒Chiropractic Care Effective ❒Y ❒N Date_____ to_____ ❒ Ongoing Region_____
❒Aqua Therapy Effective ❒Y ❒N Date_____ to_____ ❒ Ongoing Region_____
❒Opioid Effective ❒Y ❒N Date_____ to_____ ❒ Ongoing Region_____
❒Other _____ Effective ❒Y ❒N Date_____ to_____ ❒ Ongoing Region_____
(Examples: Tens, CBT, Biofeedback)

Please list any **pain** procedures you have received. (with date and doctor)

_____

**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, prescription medicine abuse or childhood sexual 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: _____
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? ❒No ❒Living will ❒DNR (do not resuscitate) ❒Prefer not to answer

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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 have these problems made it for you to do your work, take care of things at home, or get along with other people? | Not difficult at all | _____ |
| | Somewhat difficult | _____ |
| | Very difficult | _____ |
| | Extremely difficult | _____ |

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**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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# Opioid Risk Assessment Tool (OAT)- Page 1

**Patient Name:** _____ **Account Number:** _____ **Date:** _____

The following questions are for patient who are or are being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

| | Never | Seldom | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 |
| 1. How often do you have mood swings? | o | o | o | o | o |
| 2. How often have you felt a need for higher doses of medication to treat your pain? | o | o | o | o | o |
| 3. How often have you felt impatient with your Doctors? | o | o | o | o | o |
| 4. How often have you felt that things are just to Overwhelming that you can't handle them? | o | o | o | o | o |
| 5. How often is there tension in the home? | o | o | o | o | o |
| 6. How often have you counted pain pills to see how many are remaining? | o | o | o | o | o |
| 7. How often have you been concerned that people will judge you for taking pain medication? | o | o | o | o | o |
| 8. How often do you feel bored? | o | o | o | o | o |
| 9. How often have you taken more pain medication than you were supposed to? | o | o | o | o | o |
| 10. How often have you worried about being left alone? | o | o | o | o | o |
| 11. How often have you felt a craving for medication? | o | o | o | o | o |
| 12. How often have others expressed concern over your use of medication? | o | o | o | o | o |

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## Opioid Risk Assessment Tool (OAT)- Page 2

**Patient Name: _____ Account Number: _____Date: _____**

| | Never | Seldom | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 |
| 13. How often have any of your close friend had a problem with alcohol or drugs? | o | o | o | o | o |
| 14. How often have other told you that you had a bad temper? | o | o | o | o | o |
| 15. How often have you felt consumed by the need to get pain medication? | o | o | o | o | o |
| 16. How often have you run out of pain medication early? | o | o | o | o | o |
| 17. How often have other kept you from getting what you deserve? | o | o | o | o | o |
| 18. How often in your lifetime have you had legal problems or been arrested? | o | o | o | o | o |
| 19. How often have you attended an AA or NA meeting? | o | o | o | o | o |
| 20. How often have you been in an argument that was so out of control that someone got hurt? | o | o | o | o | o |
| 21. How often have you been sexually abused? | o | o | o | o | o |
| 22. How often have others suggested that you have a drug or alcohol problem? | o | o | o | o | o |
| 23. How often have you had to borrow pain medications from your family or friends? | o | o | o | o | o |
| 24. How often have you been treated for an alcohol or drug problem? | o | o | o | o | o |

Please include any additional information you wish about the above answers for your provider. Thank you.

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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. Prescriptions will be given at your office visit appointments.
8. 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 $30.00 no show fee. If you fail to appear for more than 2 appointments, you may be dismissed from our practice
9. 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.
10. 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.
11. You must sign a contract indicating that you acknowledge and understand the Medication Policy of Tulsa Pain Consultants, Inc.
12. 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

**You are responsible for copayments, deductibles and coinsurance as directed by your insurance policy and payment is expected at the time of service. For your convenience, we accept cash, checks, Visa/MasterCard, Discover, American Express and convenient monthly payment plans from Care Credit. If treatment is discontinued after payment has been received, you may receive a refund less the cost of care received. Failure to pay at the time of service may result in your appointment being rescheduled.**

**Insurance**
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 and your carrier does not require prior authorization, 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. Charges that are not covered by your carrier, we may bill you and payment is due upon receipt.

**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.

**Payment Plan/Arrangements**
Payment plans are available and are based on account balances. The balance on the account should be paid in full within 3-12 months depending on your account balance and meeting minimum payment requirements. Monthly payments are expected on your account. Failure to pay monthly on your account may result in collection efforts that may result in being discharged from the practice. Please contact our billing department immediately for further information.

**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. If work comp denies your treatment, we cannot bill your insurance company and your account will be private pay. Payment will be required at the time of service.

**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 may 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:**
If your insurance requires urine drug testing to be performed outside our office. 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.

**No Show appointments:**
If you fail to reschedule or cancel an appointment a $30.00 fee may be applied to your account.

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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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***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 reporting 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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***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, 10810 East 45th Street, Ste 400, Tulsa, Oklahoma 74146. Phone (918) 742-7030**

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**Patient Name:_____**



**Informed Consent and Patient Treatment Agreement**

As a patient, you have the right to be informed about your conditions and the recommended medical or diagnostic procedures and medications to be used, so that you may make the informed decision whether or not to agree to treatment, after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather is an effort to make you better informed so that you may give or withhold your consent to the medications which may be administered or prescribed by the Tulsa Pain Consultants ("TPC") physicians, nurse practitioners and physician assistants ("providers").

**Please read all this information carefully, as it contains important information. Ask the physicians or staff ANY questions you might have. DO NOT sign this form if you do not understand all the information or if you are not able to comprehend its terms for any reason, including medical conditions you may have or the use of any medications. Once you fully understand this information, please sign and date below, indicating your consent to treatment and agreement to follow the terms of this form.**

I understand and agree to the following:

**Risk, Benefits and Side Effects of Opioids/Narcotic Pain Medications**

I understand that I have a medical condition or conditions that includes a diagnosis of either acute or chronic pain. I understand that I may not expect complete relief from pain with opioid administration or prescriptions (sometimes called narcotics or 'pain killers'). The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there may be a limited chance for complete cure, but the goal of taking medications on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. An appropriate treatment goal may even mean the eventual withdrawal from the use of all medications. I realize that the treatment for some will require prolonged or continuous use of medications and that my condition will be evaluated on an individual basis.

**_____ Patient Initials**

It has been explained to me that these medications can be harmful if taken without medical supervision. I further understand that these medications may lead to physical tolerance or dependence and/or addiction and may produce adverse side effects or results, including decreased effectiveness, confusion, itching, difficulty urinating, allergic reactions, decreased sex drive, drowsiness, nausea or vomiting, addiction, constipation, trouble driving or operating machinery, respiratory depression (slow or no breathing) and coma. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medications. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me. These risks can occur even when the medications are prescribed and taken appropriately. Therefore, I understand it is my obligation and responsibility to take them as prescribed.

I understand that taking more of a medication than prescribed, or taking medication from another source may lead to overdose, and this could cause slowed or stopped breathing, brain injury from lack of oxygen, coma or death.

I understand that sedation and cognitive impairment may occur when I take opioids, and that caution should be exercised when operating motor vehicles or equipment, or performing other tasks where use of these medications might put myself or others at risk.

**_____ Patient Initials**

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**Patient Name:_____**



I also understand that I may experience withdrawal such as nausea, shakes, sweating, rapid heart rate, diarrhea, high blood pressure, pain or severe nervousness if I suddenly stop or even decrease the medication.
**_____ Patient Initials**

I understand that there is an increased risk of overdose associated with the use of opioids in combination with medications used to treat anxiety disorders, panic attacks, insomnia or seizures (benzodiazepines).
**_____ Patient Initials**

I understand that there is an increased risk of overdose associated with the use of alcohol in combination with prescribed opioids for pain. I understand that while I am a patient at Tulsa Pain Consultants and taking prescribed medications for pain that I will not drink alcohol.
**_____ Patient Initials**

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medications for the treatment of my chronic pain. I understand there are many treatment options, and if the alternative methods were not explained, I have asked about other treatment options. I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, noninvasive therapies such as acupuncture, stress reduction techniques, etc. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program recommended by my physician to achieve increased function and improved quality of life.
**_____ Patient Initials**

I understand that there are studies that reflect an increased risk of medical complications and even death associated with the use of extended release, long acting or high doses of opioids and that TPC providers may determine in the exercise of medical judgment, that the risks of use of these medications (or doses) outweigh the benefits. I understand that in that situation the TPC providers will recommend a treatment plan that includes schedule to reduce the amount of opioids, switch to an alternative medication with a lower risk of side effects, recommend alternative therapies or refer me to another practice.
**_____ Patient Initials**

I have been informed that the drug therapy that my physician may prescribe for me may involve using a drug that the Federal Food and Drug Administration may not have been asked by the manufacturer to review for safety for effectiveness for my condition. Current medical literature shows that such “off Pain Management label” use may be beneficial to some patients and I understand that recommended dosages for treating chronic pain are often exceeded in order to balance the benefit and risk to the patient.
**_____ Patient Initials**

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**Patient Name:_____**



I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedures to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedures and I believe that I have sufficient information to give this informed consent.
_____ **Patient Initials**

**Patient Responsibility**
I have been informed and understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs as determined by TPC providers. I agree to submit to urine and/or blood screens to detect the use of illegal, non-prescribed and prescribed medications at any time and without prior warning. Presence of illegal, unauthorized substances or the absence of prescribed medications which may indicate non-compliance may result in termination from the practice.
I understand that a positive or inconsistent preliminary finding on a drug test may require that my office visit be rescheduled until the results can be verified.
_____ **Patient Initials**

I understand that I am required to update TPC providers regarding ALL medications prescribed by any physician. I may be asked to bring my current prescribed medications in to the office for a 'pill count'. I understand that counts that are inconsistent with prescriptions or refusal to bring in prescribed medications may result in termination from the practice.
_____ **Patient Initials**

I will receive medications only from ONE physician and/or his appropriately authorized assistants unless it is for an emergency or the medications that is being prescribed by another physician is approved by my TPC provider. I will use the medications exactly as directed by my physician and /or his appropriately authorized assistants. I agree to take the medications as instructed. Any unauthorized increase in the dose of medications may be viewed as a cause for discontinuation of the treatment. Information that I have been receiving medications prescribed by other physicians that has not been approved by my TPC provider may lead to a discontinuation of medications and treatment.
_____ **Patient Initials**

I understand that my medications will be refilled on a regular basis. I understand that my prescriptions and my medications, if either are lost or stolen, may NOT BE REPLACED. Refills will not be ordered before the scheduled refill date. However, early refills may be allowed when I am travelling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medications prior to the time of my next scheduled refill, even if my prescriptions run out.
_____ **Patient Initials**

I will disclose to my TPC providers all medications that I take at any time, including but not limited to medications prescribed to treat anxiety or depression, sleep disorders or seizures (benzodiazepines) prescribed by any physician, as some of these medications in combination with opioids can increase the risk of overdose. I will notify my physician if I increase, discontinue or reduce the prescribed quantity of opioids.
_____ **Patient Initials**

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**Patient Name:_____**



I understand that at the sole discretion of TPC providers, I may be asked to obtain an opioid 'overdose kit', available from local pharmacies without a prescription. Failure to comply may result in termination from the practice.
_____ **Patient Initials**

I agree not to share, sell or otherwise permit others, including my family and friends, to have access to these medications. I will not take medications prescribed to other individuals.
_____ **Patient Initials**

I agree to read the package inserts and prescription bottle labels and will discuss any concerns regarding contraindications or reactions with my physician.
_____ **Patient Initials**

I will tell my TPC provider if I have had a reaction or am allergic to any opioid medications.
_____ **Patient Initials**

All medications will be filled at one pharmacy, which I have listed below. Should the need arise to change pharmacies, I will inform my physician. I authorize my TPC providers to release my medical records to my pharmacist at his/her discretion as long as it relates to my care at TPC. I hereby give the TPC providers permission to discuss all relevant diagnostic and treatment details with my other physicians and pharmacists regarding my care or use of medications prescribed by my TPC providers.
_____ **Patient Initials**

I agree that I shall inform any physician who may treat me for any other medical problems that I am being treated at TPC, and will provide other physicians or health care providers with a list of the medications administered or prescribed by TPC. I understand that the use of other medication, including but not limited to prescriptions for anxiety, depression, sleep disorders or seizures (benzodiazepines) in combination with opioids may cause harm.
_____ **Patient Initials**

I will notify TPC if I seek treatment for pain elsewhere or if there is a change in my medical conditions, social history (such as increased alcohol use or abuse), surgical history, relevant family history, or civil actions related to the use of opioids, narcotics, alcohol or illegal substances (for example, civil actions or child custody actions alleging that the use of prescribed or illegal substances is a cause or contributing factor to the allegations).
_____ **Patient Initials**

I will notify TPC if I am charged, convicted or received deferred adjudication/suspended sentence for ANY criminal action other than a misdemeanor such as a minor traffic offense. I understand that this includes a duty to report ANY criminal charges, including but not limited to any alcohol or drug offenses, driving while impaired or intoxicated, assault, battery, public intoxication, possession or trafficking of illegal substances, or injury to a child. I understand that this duty includes a duty to report charges, whether or not those charges are ultimately dismissed. I understand that failure to provide this information may result in termination from the practice.
_____ **Patient Initials**

I will notify TPC if a physician or court recommends or orders that I seek treatment for alcohol or substance abuse; if I am admitted to an outpatient or inpatient treatment facility for alcohol or substance abuse; or if seek treatment, whether voluntarily or by court order, in a substance abuse program such as AA, NA or Celebrate Recovery.
**_____ Patient Initials**

I will keep follow-up appointments to the best of my ability. I understand failure to keep follow up appointments may be grounds for termination from the practice.
**_____ Patient Initials**

I agree that in the event I experience suicidal or homicidal thoughts, I WILL SEEK IMMEDIATE MEDICAL HELP by calling my physicians, the therapist, or 911 and/or going to the nearest Emergency Room for an assessment and treatment.
**_____ Patient Initials**

**Grounds for Termination from TPC**
I understand that inconsistent drug screen results, refusal to submit to urine testing, refusal to bring medications for pill count, use of illegal substances, alcohol abuse, evidence of obtaining opioids from another provider, taking medications not prescribed for me, giving or selling my medications to another person, certain criminal and/or civil charges, providing materially false information, failing to provide required information, noncompliance with the treatment plan and continued cancellation of office visits, among other things, may lead to termination from TPC.
**_____ Patient Initials**

**Treatment Goals**
My progress will be periodically evaluated. If it appears to the TPC providers that there are no demonstrable benefits to my daily function or quality of life from the medications, that I am developing a tolerance, if the risks outweigh the benefits or if other medical conditions or medications have the potential to negatively affect the current medication regimen, then they may try alternative medications, taper me off all medications, recommend alternative treatments and therapies or refer me to another practice.
I understand that I am to be an active participant in my treatment plan and goals.
**_____ Patient Initials**

**For female patients only:**
To the best of my knowledge I am NOT pregnant.
If I am not pregnant, I will use appropriate contraception during my course of treatment. I promise and it is MY responsibility to inform the TPC providers immediately if I become pregnant. If I am pregnant or am uncertain, I WILL NOTIFY the TPC providers IMMEDIATELY. Besides the possible risks involved with the long-term use of opioids, I further understand that information on the effects of medications on pregnant women and their unborn children is at present inadequate to guarantee that I and/or my unborn children may not experience significant or serious side effects. All of the above possible effects of medications have been fully explained to me. With full knowledge of this, I consent to its use and hold TPC harmless for injuries to the embryo / fetus / baby which may be associated with the use of opioid medications.
**Patient Initials: _____**

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**Patient Name:_____**



**CONSENT TO TREATMENT AND/OR DRUG THERAPY:**

I understand that this agreement relates to my use of any and all medications for acute or chronic pain.
I am voluntarily requesting the TPC providers to treat my condition of acute or chronic pain with appropriate medications and other interventions. I understand that TPC has relied on the information I have provided verbally and in writing to select appropriate medications and treatment, and I state that this information is complete and accurate. I understand that intentionally providing misleading or incomplete information is grounds for termination from the practice.
I voluntarily request the TPC providers, as the practice may deem necessary or advisable, to treat my condition which has been explained to me as acute or chronic pain.
I have received and agree to the terms of the Patient Education form and the Medication Policy.
I hereby authorize and give my voluntary consent for TPC providers to administer or prescribe the prescriptions for opioids as an element in the treatment of my chronic pain.
I certify and agree to the following:
1) I am not currently using illicit drugs or abusing prescription medications and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.
2) I have never been involved in the sale, illegal possession, diversion or transport of controlled substances (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.).
3) No guarantee or assurance has been made as to the results that may be obtained from pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to treatment.
4) I will ensure that all questions regarding the use of the medications prescribed have been fully explained, and that if I do not understand the explanation or if I have continued questions I will continue to ask questions until I am satisfied with the answers. I understand that this is my right as a patient.

**_____ Patient Initials**

_____
**Pharmacy Name**

_____
**Patient Name (please print)**

_____
**Patient Signature / Date**

_____
**Witness Signature / Relationship to Patient / 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)**

xxx-xx-_____

**Last 4 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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Phone: (918) 742-7030 Fax(918) 742- 9958

## 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 _____

TULSA PAIN
CONSULTANTS
Phone: (918) 742-7030 Fax(918) 742- 9958

# 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, change or verify appointments and/or discuss care.**

_____ _____
**PRINT Patient or Patient's Legal Representative** **Date**

_____ _____
**Patient or Patient's Legal Representative Signature** **Date**

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

| | |
|---|---|
| _____ | _____ |
| **Name** | **Relationship to patient** |
| _____ | _____ |
| **Name** | **Relationship to patient** |
| _____ | _____ |
| **Name** | **Relationship to patient** |
| _____ | _____ |
| **Name** | **Relationship to patient** |
| _____ | _____ |
| **Name** | **Relationship to patient** |
| _____ | _____ |
| **Name** | **Relationship to patient** |