PAIN CARE CENTERS
Treatment Options Close to Home

Dear Patient,

We are happy you are considering seeing us for your pain management needs. We pride ourselves on providing the best, comprehensive pain care available in our communities. Please find and complete the following documents prior to your first appointment. Please come at least 30 minutes early. If you haven't completed the forms prior to your appointment, please come 45 minutes early.

NOTICE: A "NO SHOW" FEE OF $35 WILL BE CHARGED FOR NO SHOWS AND CANCELLATIONS LESS THAN 24 HOURS PRIOR TO YOUR APPOINTMENT. *Certain exclusions apply.

Forms:

- ❏ Information Form Including ALL Insurance Info
- ❏ New Patient Intake Form (Do not complete pages that say "Office Use Only"
- ❏ Consent Forms and Agreements

Items of note or needed in addition to the above-listed forms:

- ❏ Driver's License or Other ID and ALL Insurance Cards
- ❏ List of ALL Medications
- ❏ Medical Records From Other Providers Relative to the Reason for Your Appointment (Imaging, Dr. Notes, etc.)
- ❏ An Email Address: We will establish a "Patient Portal" for you which allows you to access records and communicate with our office.
- ❏ Spouse or Other Family: We encourage you to involve your family in your Pain Management.
- ❏ Urine Drug Testing: Be prepared to provide a sample.
- ❏ Payment of Deductibles and Copays are Always Due at Time of Service.

Please be sure to thoroughly review all documents and forms and complete as accurately and truthfully as possible as this information will provide a basis for your care going forward.

You may bring the forms into our practice ahead of time, fax them or simply bring them with you to your appointment. See the list of our locations below.

Please call 307.212.6270 for any questions or concerns. We look forward to serving you.

2620 Commercial Way, #20
Rock Springs, WY 82901
(307) 212-6270 Office
(307) 212-6271 Fax

329 Main Street
Lander, WY 82520
(307) 212-6270 Office
(307) 212-6271 Fax

170 Arrowhead Dr, #2
Evanston, WY 82930
(307) 212-6270 Office
(307) 212-6271 Fax

5850 E 2nd Street, Ste 100
Casper, WY 82609
(307) 212-6270 Office
(307) 212-6271 Fax

Patient Demographic/Insurance Information Form | Date:

Name: _____
Last First M.I.
Sex: _____ Date of Birth: _____ S.S.# _____

Address: _____
Street City State Zip Code

Phone Numbers : Home: _____ Work:_____ Cell:_____

Employer: _____ □ Full Time □ Part Time

Emergency Contact: _____ Phone Number:_____

Who is your primary care physician? _____

Who is your referring physician? _____

Race:
□ American Indian/Eskimo/Aleut □ Afro-American □ White □ Hispanic/Latino □ Asian
□ Native Hawaiian/Pacific Islander □ Other □ Decline to respond

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other

Insurance Information

Primary Insurance Company: _____

Insurance Address: _____
Street City State Zip Code

Subscriber (policy holder) _____
Policy Number: _____Group Number: _____
Policy Type: □ Individual □ Group □ Supplemental □ Other:_____
Policy type: Patient relationship to subscriber(policy holder): _____
Policy holder's S.S. # _____ Policy holder DOB:_____

Secondary Insurance Company:_____

Insurance Address: _____
Street City State Zip Code

Subscriber (policy holder) _____
Policy Number: _____Group Number: _____
Policy Type: □ Individual □ Group □ Supplemental □ Other:_____
Policy type: Patient relationship to subscriber(policy holder): _____
Policy holder's S.S. # _____ Policy holder DOB:_____

NAME:_____ **DOS:** ____ **Suboxone 1/3**

1. Why are you seeking treatment?

2. When and why Dependency developed
Age you started using drugs: _____
Reason:
_To get high
_To deal with stress
_To fit in
_To perform better/ have energy,

3. What drugs are you currently using?
_Alcohol _Marijuana _Meth _Cocaine _Xanax _Valium _Klonopin _Norco _Morphine _Oxy _Fentanyl _Heroin _Methadone _Other:__

4. What drugs have you used in the past?
_Alcohol _Marijuana _Meth _Cocaine _Xanax _Valium _Klonopin _Norco _Morphine _Oxy _Fentanyl _Heroin _Methadone _Other:__

5. How have you used drugs?
_Swallow _Snort _Smoke _Inject _Under Tongue _Rectum/Vagina

6. How much do/have you use(d) in a single day? (mg or $) _____

7.Treatments for drug dependency: _None _Yes: Write below your past treatments
_Outpatient treatments: Where?_____ When_____
_Inpatient treatments : Where?_____ When_____
_Have had Buprenorphine (Suboxone) for treatment

8. Hepatitis C status: _ I do not know _Positive _Negative
9. HIV (AIDS) status: _ I do not know _Positive _Negative

10. Last time you used any drugs: _____.
11. What did you use? _Alcohol _Marijuana _Meth _Cocaine _Xanax _Valium _Klonopin _Norco _Morphine _Oxy _Fentanyl _Heroin _Methadone _Buprenorphine (Suboxone)

Check all that applies to you:
12. _Opioids are often taken in larger amounts or over a longer period of time than intended.
13. _There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
14. _A great deal of time is spent in activities necessary to obtain the opioids, use them, or recover from its effects.
15. _Craving, or a strong desire to use opioids.
16. _Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
17. _Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
18. _Important social, occupational or recreational activities are given up or reduced because of opioid use.
19. _Recurrent opioid use in situations in which it is physically hazardous
20. _Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
21._ *Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid
22. _*Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms.

NAME:_____ **DOS:** ____ **Suboxone 2/3**

23. Employment: _Unemployed _Retired _Homemaker _Disability benefits _Working as_____

24. Education Level: _High School _2yr. College _4 yr. college _Masters _Doctorate/Ph.D

25. Tobacco: _Never Smoker _Former Smoker _Current Smoker _Chews

26. Alcohol : _Never Drinker _Former Drinker _Current Drinker _Drinks per week:_____

27. Marital Status: _Single __Divorced __Separated __Widowed __Married

28. Allergies: _NONE (NKDA), Yes:_____

29. ROS (Symptoms): Have you had any of these in the last 30 days? _NONE

_ Anxiety
_ Depression
_ Insomnia
_Suicidal Thought
_Constipation
_Diarrhea
_Tarry Stool
_Nausea/Vomit
_Heartburn
_ Difficulty Breathing
_ Persistent cough
_ Sleep Apnea
_Sweating a lot
_General Achiness
_Goose flesh skin
_Cold/Heat intolerance
_Craving
_Runny Nose/Teary Eyes
_Frequent Falls
_Slurred Speech
_Sedation
_Tremors

_Hearing Loss
_Yellow Eyes
_Vision changes
_Dry Mouth
_Easy bruising
_On Blood thinner
_Enlarged Lymph Node
_Hair loss
_Yellow skin
_Nail changes
_Wt Loss
_Fatigue
_Leg Swelling
_Fast Heart Rate

.

30. Medication List: _NONE, I do not take any.

31. Your **Pharmacy Name:**_____

Medication	Dosage	Per day	Medication	Dosage	Per day
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

32. Medical Conditions you have had: __**NONE**

_ADD
_Anxiety
_Arthritis
_Asthma
_Bipolar
_Cancer
_Chronic Fatigue
_COPD
_Cirrhosis
_Depression
_Diabetes
_DVT
_Fibromyalgia
_GERD
_Glaucoma
_GOUT
_Heart Attack
_Heart Disease
_High BP
_High Cholesterol
_Hepatitis
_HIV
_IBS
_Kidney Disease
_Migraine
_Osteoprosis
_PVD
_Sleep Apnea
_Seizure Disorder
_Stroke
_Hypothyroid
_Other:_____

33. Surgical Operations you have had: **__NONE**

_Neck _Wrist (Carpal Tunnel)
_Back
_Shoulder
_Elbow
_Hip
_Knee
_Ankle
_Appendectomy
_Breast
_Heart bypass surgery
_C Section
_Gallbladder
_Hernia
_Hysterectomy
_Other:_____

34. Family History: _NONE

_Arthritis
_Asthma
_Cancer
_Chronic Pain
_Dementia
_Depression
_Diabetes
_Heart Disease
_High BP
_High Cholesterol
_Kidney Disease
_Liver diseases
_Osteoporosis
_Stroke
_Obesity
_Alcohol/Drug Abuse

Signature: _____

NAME:_____ **DOS:** ____ **Suboxone 3/3**

Office Use Only

35. MA please complete BP:_____/____ P: ____ RR: _____ WT:_____ Ht: _____

Provider:
Diagnostics Reviewed: _UDS _PDMP _Imaging _EKG/ QTC: _Records

Exam
General: _anxious _ depressed _emotional, _good/poor Insight _good/poor Judgement

HEENT: _ Dental decay/loss _ jaundiced sclera

LYMPHATICS: _ lymphadenopathy.

RESPIRATORY: _wheezing

CARDIAC: _tachycardic

SKIN: _Needle marks, _jaundiced

Assessment
Primary diagnosis: OUD: _Mild, DSM5: 2-3 F11.10 _Mod, DSM5: 4-5 F11.20 _Severe, DSM5: 6 or more symptoms. F11.20

Comorbid diagnosis: _Anxiety _Depression _N/V _ADD _Tobacco use _Alcohol Use _Other

Medical/Surgical/Radiological diagnosis: _Chronic pain _Other

Plan:
Treatment of the comorbid issues: Anxiety/depression/ADD/Other:
_Discussed importance of treating comorbid condition:
_Discussed importance of participation with a group program such as NA, AA
_Recommend counselling. _____
_Recommended Pharmacological treatment: _____

Treatment of Primary diagnosis: OUD
_Pharmacological:
_Suboxone: _Start _Continue _Risks and Benefits discussed _Pamphlet
_Clonidine: .2 mg tid max dose 1.2 mg/24 hrs. For anxiety/diaphoresis/other withdrawal symptoms
_Consider: _Loperamide for diarrhea _NSAIDS for muscle pain _Ondansetron for N/V
_Discussed importance of participation with a group program such as NA,AA
_Recommend counselling. _____

Treatment of Medical/Surgical/Radiological diagnosis: Chronic pain/Other
_PM&R: _HEP _TENS _DDS _LSO
_IPM: Referral

Plan for Aberrant Behavior:
_Medication agreement discussed _Frequent visits _UDS/UDT _Pill Count _PDMP _OUD to Pain Reclassification
_Informed Consent was obtained.

_**ORDER:** _Blood work, CBC, CMP, Hep Panel, HIV _Obtain Records:_____

FU:_____

Provider: _____

Name:_____ **DOB:**_____ **Date of Service:**_____

PHQ9

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

1. Little interest or pleasure in doing things:
   _Not at all (0) _Several days (1) _More than half the days (2) _Nearly everyday (3)

2. Feeling down, depressed, or hopeless:
   _Not at all (0) _Several days (1) _More than half the days (2) _Nearly everyday (3)

3. Trouble falling or staying asleep, or sleeping too much
   _Not at all (0) _Several days (1) _More than half the days (2) _Nearly everyday (3)

4. Feeling tired or having little energy:
   _Not at all (0) _Several days (1) _More than half the days (2) _Nearly everyday (3)

5. Poor appetite or overeating:
   _Not at all (0) _Several days (1) _More than half the days (2) _Nearly everyday (3)

6. Feeling bad about yourself or that you are a failure or have let yourself or your family down
   _Not at all (0) _Several days (1) _More than half the days (2) _Nearly everyday (3)

7. Trouble concentrating on things, such as reading the newspaper or watching television
   _Not at all (0) _Several days (1) _More than half the days (2) _Nearly everyday (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
   _Not at all (0) _Several days (1) _More than half the days (2) _Nearly everyday (3)

9. Thoughts that you would be better off dead or of hurting yourself in some way
   _Not at all (0) _Several days (1) _More than half the days (2) _Nearly everyday (3)

Total Score: _____

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

1-4:MIN. 5-9:MILD. 10-14: MOD. 15-19:MOD. to SEV. 20-27: SEV.

Name:_____ DOB:_____ Date of Service:_____

AUDIT

1. How often do you have a drink containing alcohol?
(0) Never (Skip to Questions 9-10)
(1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
(0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more

3. How often do you have six or more drinks on one occasion?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
(0) No (2) Yes, but not in the last year (4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?
(0) No (2) Yes, but not in the last year (4) Yes, during the last year

SCORE:____

Name:_____ DOS_____

MEDICATION AGREEMENT

Please review and sign this agreement if you are going to receive controlled substances from our practice.

The purpose of this agreement is to give you information about the medications you will be taking for your condition and to assure that you and your provider comply with all state and federal regulations concerning the prescribing of controlled substances. The provider's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the Provider(provider)/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat your pain related conditions.

1. You should use only use **Pain Care Centers** to prescribe and monitor all opioid medications and adjunctive analgesics. The providers may allow you to receive certain medication by other providers when notified..
2. You should use one pharmacy to obtain all opioid prescriptions and adjunctive analgesics prescribed by your Provider. An exception to this is allowed when your regular pharmacy does not carry the medication or the medication can be obtained cheaper at another pharmacy.
3. You should inform your Provider of all medications you are taking, including herbal remedies, since opioid medications can interact with over-the-counter medications and ALL other prescribed medications.
4. You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment.
5. Prescriptions for pain medicine or any other prescriptions will be done only during an office visit or during regular office hours or as authorized by your provider.
6. You agree to bring in controlled medication being taken when asked to do so and be prepared to submit to urine drug testing.
7. You are responsible for keeping your medication in a safe and secure place, such as a locked cabinet or safe. You are expected to protect your medications from loss or theft. Stolen medications should be reported to the police and a case number obtained. You need this to get a replacement medication. However, we may choose to not to replace the medications or to taper and discontinue the medications.
8. You may not give or sell your medications to any other person under any circumstances. If you do, you may endanger that person's life and it could be a violation of the law.
9. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other providers (includes emergency room providers), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.
10. You agree to report any concern or complaint about your treatment when you come in for a visit. You agree to report, fully and truthfully, your pain level and functional activity along with any side effects of the medications at each office visit on the forms provided to you.
11. You should not use any illicit substances, such as cocaine, marijuana, etc. while taking these medications. If you do, it may result in a change to your treatment plan, including discontinuation of your opioid medications when applicable or complete termination from the practice.
12. The use of alcohol and opioid medications is contraindicated. The mixture can be lethal.
13. There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, impaired breathing, impaired cognitive (mental status) and/or motor ability, and immunosuppression.
14. Physical dependence and/or tolerance can occur with the use of opioid medications.
Physical dependence means that if the opioid medication is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal physiological response. The withdrawal syndrome could include, but not exclusively, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in one's mood. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone. Addiction is a primary, chronic neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life. Tolerance means a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time.
15. If you have a history of alcohol or drug misuse/addiction, you must notify us of such history since the treatment with opioids for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery is a must.
16. At any time during or after your treatment at this office, you agree to allow us to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions *if we feel it is necessary for your safety or the safety of public.* You agree to a family conference or a conference with a close friend or significant other *if we feel it is necessary for your treatment, safety or the safety of public.*

Signature:_____

Name:_____ DOS_____

HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may us or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy note; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Name:_____ DOS_____

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e., electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

HIPAA Privacy Rule of Patient Authorization Agreement Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my health care, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement
Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- That this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested
- ;I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Name:_____ DOS_____

Consent to Treat

I hereby give my permission for **Pain Care Center** to give me medical treatment.
I allow the Practice to file for insurance benefits to pay for the care I receive.
I understand that:

- the Practice will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.
The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record.
Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.
It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.
Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.
I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

By signing this consent form:

1) You acknowledge the **receipt of TWO HIPPA notices.**
2) You are giving your healthcare provider **permission to collect and share your** pharmacy and your health insurer **information about your prescriptions** that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.
3) You give **consent to obtain your medication history.**
4) You give you **consent to treat.**

Signature:_____

DOMINION DIAGNOSTICS

PATIENT RELEASE FORM

Dominion Diagnostics is the clinical laboratory that your physician or healthcare provider has chosen to integrate into his or her practice and your treatment at _____.
(PRINT TREATMENT FACILITY NAME)

Dominion's laboratory offers clinical urine drug testing and monitoring that provides key clinical information to your physician or healthcare provider regarding prescription adherence, illicit drug usage, and drug elimination.

When applicable, Dominion Diagnostics will bill your health insurance provider for the clinical urine drug testing services performed at its laboratory and accept reimbursement as determined by your coverage plan.

Patient Authorization:

I _____, _____authorize Dominion Diagnostics to:
(PRINT PATIENT NAME) (PRINT PATIENT DATE OF BIRTH)

(1) Release the laboratory test results to the ordering facility listed above and to my treatment providers.
(2) Bill my insurance provider for necessary charges associated with laboratory testing performed.
(3) Receive payment from your health insurance provider for the laboratory testing performed.
(4) Collect from your treatment provider and utilize any medical information necessary to process the insurance claim.

I further understand that Dominion Diagnostics will bill my insurance provider its Usual and Customary Charge for the testing ordered by my physician or healthcare provider. I understand that I am responsible for any co-pays, deductibles, or other fees that my insurance provider deems my responsibility.

If my insurance provider should reimburse me directly, I agree to endorse the check and send it to Dominion Diagnostics within 30 days. Otherwise, I am responsible for the amount owed.

I understand I may contact Dominion Diagnostics Billing Department at 1-800-511-8427, Option 4 to discuss any questions or concerns regarding payment or to receive information on Dominion's financial assistance program.

FINANCIAL STATUS QUALIFICATION STATEMENT

Financial Hardship (Indigent) _____ **Yes** _____ **No**

Patient qualifies as indigent per the following definition: Patient is receiving free or reduced care from the Treatment Facility listed above, has no health insurance, and is unable to pay the Usual and Customary Charge without financial hardship. The Treatment Facility shall maintain, and make available to Dominion Diagnostics if requested, financial records verifying "indigency" status.

_____ _____
Authorized Treatment Facility Signature (REQUIRED) **Date**

SIGN HERE

_____ _____ _____
Patient Signature (REQUIRED) **Parent/Legal Guardian Signature (REQUIRED FOR CHILDREN UNDER 18 YEARS OLD)** **Date**

NOTE: This release is in effect for the patient's entire length of treatment.

DOMINION DIAGNOSTICS

REDUCED RATE REQUEST FORM

Please fill out this form to request a Reduced Rate for services provided by Dominion Diagnostics

PATIENT INFORMATION

ACCOUNT NUMBER _____

PATIENT NAME _____

DATE OF BIRTH _____

ADDRESS ON FILE* _____

CITY/STATE/ZIP _____

PHONE _____

*IF NECESSARY, PLEASE PROVIDE AN UPDATED ADDRESS AND/OR PHONE NUMBER BELOW.

NEW ADDRESS _____

NEW CITY/STATE/ZIP _____

NEW PHONE _____

HOUSEHOLD INCOME INFORMATION**

CURRENT GROSS OR ADJUSTED GROSS ANNUAL INCOME (SELF) $ _____

CURRENT GROSS OR ADJUSTED GROSS ANNUAL INCOME (SPOUSE/PARTNER) $ _____

COMBINED TOTAL GROSS OR ADJUSTED GROSS ANNUAL INCOME (FAMILY) $ _____

TOTAL PERSONS IN HOUSEHOLD (INCLUDING SELF) _____

PATIENT ACKNOWLEDGMENT & SIGNATURE

I hereby acknowledge the above information is true and accurate. I authorize Dominion Diagnostics to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation for the above request (e.g., W-2, paystub). I understand that if I do not qualify for a reduced rate, I will be notified by Dominion Diagnostics and responsible for my full bill. I hereby acknowledge that I am neither related to, nor employed by, the provider who ordered the testing.

SIGN HERE _____ _____

Patient Signature Date

INTERNAL USE ONLY

Statement: _____

Reviewed by: _____

☐ APPROVED ☐ DENIED Reason for Denial: _____

SUBMIT FORMS TO:

Fax **(401) 667-0331 (HIPAA Secure)**

Mail **Dominion Diagnostics, ATTN: Billing**
PO BOX 638889
Cincinnati, Ohio 45263-8889

FOR INQUIRIES, PLEASE E-MAIL:
patientinfo@dominiondiagnostics.com

QUESTIONS? Please call Dominion Diagnostics Billing Department at 1-800-511-8427, Prompt 4.

VERSION: 14-1003