<u>New Patient Letter</u>

Date: ___________________
Dear Patient: ____,
(enter patient name)

<u>Please note that ALL new patient paperwork must be filled out in its entirety in order to be seen by any provider</u>. This is true for any type of appointment (i.e., second opinion, injections, medication management). There are no exceptions.

As part of our care for you (Patient), we provide this letter to tell you about Arizona Pain Care Center (AZPCC) general practice policies and position on using controlled substances, such as opioids (narcotics), to treat pain. **After you read this letter, tell your provider if you have any questions**.

We will explore the medical treatment options within the scope of our medical practice to help you regain function and lead an active and healthy life. We use a variety of treatment methods to accomplish treatment goals, including: *physical therapy, basic injection procedures, heat and/or cold therapy, a home exercise program and non-controlled medications*. We require **all** our patients to have a Primary Care Physician (PCP), and we expect you to help us obtain your medical records from your PCP and any other doctor who has treated you using controlled medications.

AZPCC is a treatment center for interventional pain relief. AZPCC **may, at provider discretion,** prescribe long-term use-controlled substances for chronic pain control. AZPCC uses injections and minimally invasive techniques to help diagnose and treat painful conditions. In addition, AZPCC may choose to prescribe a controlled substance for an acutely painful condition on a short-term basis. AZPCC **does not** prescribe both an opioid and benzodiazepine in combination unless there is an indication to do so deemed appropriate by a psychiatrist. Furthermore, the appropriateness of any patient to be a candidate for opioid therapy is to be determined by the treating physician. An initial evaluation at AZPCC does not guarantee that a prescription for an opioid will be written at the first visit or any subsequent visit.

Strict federal and state laws and regulations govern us when we prescribe controlled substances. To help us meet these laws and regulations and provide you with the most effective care, we may ask that you provide the information and complete the tasks in connection with our patient selection and treatment process, as follows:

1. Get information from you and your other doctors about your medical history and your past pain treatments, including a list of all medication you take to treat your pain;
2. Ask you whether you or anyone in your family has a problem with alcohol, illegal drugs, legal drugs, or tobacco; and
3. Ask you to provide a urine sample for testing as part of the initial patient selection process. Also, we may ask you to submit to additional urine samples as part of your ongoing treatment program. All urine samples are requested at the discretion of your healthcare practitioner and you will be asked to cooperate with us or we may need to find a way to treat you without controlled medications.

We will monitor your medical condition and supervise your use of medication using various tools in addition to urine drug testing, including: medication counts, family conferences, psychological consultations, etc. We do not intend to offend you when we use these tools in our practice.

We are committed to treating you and doing what is medically acceptable and appropriate for you to help you control your pain. We look forward to serving you and helping you control your pain.

In partnership,

Arizona Pain Care Center

Demographic Information

Patient Name: ____ Sex: ☐ M ☐ F Age: _____
First Middle Initial Last

Date of Birth: _______________ Race: ____________________ Ethnicity: _____________ Preferred Language:____________

SSN#: __________________________ Home Phone: ________________________ Cell Phone: __________________

Email Address: ____ Marital Status: ☐ M ☐ S ☐ D ☐ W

Education: ____________________________________ Occupation: ____

Address: ____
Street City State ZIP

Emergency Contact:____
Name Relationship Phone #

Referring Physician: _________________________________ Phone Number:___________________________________

Insurance Information

Primary Insurance Company: ____
Name Phone #

Address to File Claim: ____
Street City State ZIP

Name of Insured: ____ Relationship to Patient: ______________________

ID#: ____________________________ Policy #: __________________________ Group #: ______________________

Secondary Insurance Company: ____
Name Phone #

Address to File Claim: ____
Street City State ZIP

Name of Insured: ____ Relationship to Patient: ______________________

Workman's Compensation
(if applicable – leave blank otherwise and go to signature line at the bottom of this page)

Claim #: ___________________________

____
Company Street City State ZIP

Caseworker: _____________________ Case Worker Phone #: ____________________ Date of Injury: _________________

By signing below, I acknowledge that Arizona Pain Care Center will file my insurance claim for me. As the Guarantor, I agree that all charges that are not directly paid by my insurance company will be my responsibility.

Patient Signature: ____

Patient Treatment Agreement (Contract)

This Agreement is by and between Samir P. Patel, D.O. / Chad Pletnick, M.D./Shannon Morgenstern, NP/ Katherine Grimes, NP / Rebecca Shiao, NP/ Patricia Bonasera, NP dba Arizona Pain Care Center (hereinafter referred to as "AZPCC") and ____________________________________ (hereinafter referred to as "Patient").

The purpose of this Agreement is to protect/prohibit patient's access to short-term and long-term use-controlled substances. It is also to provide AZPCC with the patient's information necessary to have the ability to prescribe short-term use-controlled substances for patient when he/she are enduring an acutely painful condition. Additionally, patient herein below gives consent to the administration of addictive medications that may have potential side effects and to the disclosure of medical information and documentation.

AZPCC is a treatment center for interventional pain relief. AZPCC, may, with provider discretion, prescribe long-term use-controlled substances for chronic pain control. AZPCC uses injections and minimally invasive techniques to help diagnose and treat painful conditions and may choose to prescribe a short-term use-controlled substance for an acutely painful condition or long-term use-controlled substances on provider discretion. AZPCC **does not** prescribe both an opioid and benzodiazepine in combination unless there is an indication to do so deemed appropriate by a psychiatrist. There is a risk of an addictive disorder developing within patient and/or of a relapse occurring with a patient who has had a prior addiction to any controlled substance. The extent of these risks is never certain.

By signing this agreement, patient understands the complications and risks associated with taking any controlled substance. Patient acknowledges and understands the complications and risks to include, but not be limited to, forming a chemical dependence or addiction, severe constipation, difficulty with urination, nausea, drowsiness, sweating, itching, sexual dysfunction, sleeping abnormalities, edema, and incomplete pain relief. Patient further understands that if he/she takes more medication than prescribed, a dangerous situation could result such as organ damage, coma and/or death. Thus, Patient agrees and acknowledges that it is extremely important to take his/her medication exactly as prescribed by AZPCC and his/her PCP and will not increase the dose or frequency without consulting with AZPCC and his/her PCP first.

By initialing at the end of this paragraph, Patient understands that in addition to what is set forth above, taking any controlled substance may impair his/her alertness, coordination and ability to think clearly. Any controlled substance may cause confusion, drowsiness, sedation (potentially excessive), and the possibility of impaired cognitive (mental status, thinking) and motor (movement, coordination) ability. There is a great possibility that this will make it unsafe for patient to drive a vehicle (including cars, motorcycles, boats, tractors and any other heavy machinery), operate hazardous equipment, serve in any capacity that relates to public safety or involve his/herself in any activity that could endanger his/herself or others. If patient feels impaired in any way at all, by initialing here he/she agrees to **NOT** drive a vehicle (including cars, motorcycles, boats, tractors and any other heavy machinery), operate hazardous equipment, serve in any capacity that relates to public safety or involve his/herself in any activity that could endanger his/herself or others. Patient agrees to consult with his/her pain provider or PCP prior to attempting to do any of the above.

Initials: ________

Patient understands that dangerous side effects may occur if the medications prescribed by AZPCC are taken with any other medications (including over the counter medications) or mixed with alcohol or illegal substances. By initialing at the end of this paragraph, the Patient understands and agrees to not consume any alcohol on days he/she are taking any controlled substance prescribed from AZPCC. Patient also agrees to not use illegal drugs at any time.

Initials: ________

AZPCC acknowledges that the short-term use-controlled substances that may be prescribed by AZPCC have the potential for abuse or diversion, and strict accountability by Patient is necessary. For this reason, Patient agrees to the following as consideration for and a condition of the willingness of AZPCC to consider the prescription of short-term or long-term - use controlled substances to treat patient's acute and/or chronic pain:

1. **PHARMACY INFORMATION.** All controlled substances must be obtained at the same pharmacy, where and when possible. Please provide the following information:

   Pharmacy Name: ____

   Pharmacy Phone: ____

   Pharmacy Address (cross streets): ____
   Patient will notify AZPCC if he/she decides to change to a different pharmacy.

3. **PATIENT COMMUNICATION TO AZPCC.** Patient is expected to inform AZPCC of any new medications or medical conditions, as well as any adverse effects experienced from any of the medications taken.

4. **PATIENT HISTORY.** AZPCC has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other medical professionals for the purpose of maintaining proper care for patient. Further, patient understands and authorizes AZPCC to look up Patient's current and past history of controlled substance use in the State of Arizona using the Arizona Board of Pharmacy online database. Information gathered from this website may result in disclosure to other medical professionals, medical facilities, and/or pharmacies. Information obtained may also result in the dismissal of patient from treatment at AZPCC.

5. **PATIENT RESPONSIBILITY.** By signing this Agreement, Patient is personally responsible for any and all controlled substances prescribed to them. Patient is solely responsible for the safety, storage and safekeeping of any and all controlled substances prescribed to them by AZPCC and/or his/her PCP. Patient will not share, sell, or otherwise permit others to have access to these medications, for any reason or at any time. Patient is aware that prescriptions and bottles of controlled substances may be sought by individuals who have a chemical dependency and that it is up to patient to prevent any individual from having access to Patient's prescribed controlled substances. Patient also understands that controlled substances may be hazardous or lethal to a person who is not tolerant to its effects, especially a child, and will therefore keep any and all controlled substances out of the reach of all people, especially children.

6. **DRUG TESTING.** Patient understands his/her cooperation is required for unannounced urine or serum toxicology screens. By initialing at the end of this paragraph Patient consents to any and all such screens as dictated by AZPCC and/or his/her PCP. The presence of unauthorized substances may prompt referral for assessment for addictive disorder, discontinuation of therapy with controlled substances and discharge from AZPCC. If Patient refuses this testing he/she will be discharged by AZPCC.

   Initials: ________

7. **PRESCRIPTION REPLACEMENT.** Patient is aware that he/she will not have his/her medication replaced if the medication is lost, water-damaged, destroyed, left on an airplane, in a cab, on the bus, or if he/she "run out early", etc. If Patient's medication has been stolen and he/she immediately completes a police report regarding the theft and bring documentation to prove such occurrence, an exception may be made.

8. **PROCEDURE.** Patient understands that he/she may be required to bring the original containers of medication to each office visit.

9. **CONFIDENTIALITY WAIVER.** If the responsible legal authorities have questions concerning patient's treatment, as might occur, for example, if medications were being obtained from several pharmacies, all confidentiality is waived by patient and these authorities may be given full access to AZPCC's records of controlled substances administration. Patient agrees to waive his/her right to privacy and authorize AZPCC to discuss his/her medical care, information in AZPCC's patient file and use/misuse with any healthcare provider, local emergency rooms, emergent care centers, legal authorities, pharmacies or the DEA.

Initials: ________

10. **TRIAL PROGRAM.** Patient understands that any medical treatment at AZPCC is initially a trial, also thought of as short-term care, and that continued prescriptions and treatment will be contingent on the evidence of benefit and dependent upon the discretion of Patient's PCP.

11. **PARTICIPATION.** Patient recognizes that pain management represents a complex problem, which may benefit from physical therapy, psychotherapy and behavioral medicine strategies. Patient also recognizes that his/her active participation in the management of his/her pain is extremely important. Patient agrees to actively participate in all aspects of the pain management program to maximize functioning and improve coping with his/her condition, which participation includes but is not limited to:

    a. Asking questions of Patient's PCP and/or pharmacist
    b. Gathering and reading this Agreement and all information directed to Patient and/or otherwise available to Patient

12. **DISCHARGE.** By initialing at the end of this paragraph, patient understands that AZPCC and/or his/her PCP may stop treating them as a patient, at his/her sole discretion. If patient is discharged from the program at AZPCC or with his/her PCP for misuse of controlled substances, then local area emergency departments and urgent care centers will be notified. Moreover, patient's PCP may refer patient to a substance abuse specialist if he/she has concerns about patient's well-being.

Initials: ________

13. **EXPOSURE CONSENT.** Patient consents to immediate blood testing for infectious diseases **only** in the event a health care worker is exposed to patient's blood or bodily fluids through an open wound or mucous membranes or receives a needle stick during the course of patient treatments at AZPCC.

14. **FEMALE PATIENTS.** Patient understands that taking doses of controlled substances during pregnancy can be harmful to developing babies/fetuses. Patient will do everything he/she can to avoid getting pregnant while taking these medications. To the best of patient's knowledge, patient is not pregnant now. Patient will notify AZPCC if he/she plans on becoming pregnant.

15. **GOVERNING LAW.** This Agreement and the transactions contemplated herein have been consummated in the State of Arizona and shall be construed and enforced in accordance with and governed by the laws of such State, without regard to conflict of laws. This Agreement shall be governed by and interpreted in accordance with the laws of the State of Arizona.

Patient affirms that he/she have full right and power to sign and be bound by this Agreement. Patient has read this contract and it has been explained to Patient by AZPCC. Patient understands and agrees to all the terms and conditions of the above Agreement and understands any violation may result the termination of his/her care from AZPCC. Patient has received a copy of this Agreement for his/her records.

____ ______________________________

Patient Signature Date and Time

____ ______________________________

Person Legally Authorized to Sign for Patient Date and Time

____

Relationship of Person Signing Above to Patient

___________________________________ ______________________________

Witness (will be signed by AZPCC staff) Date and Time

____ ______________________________

Provider Date and Time

dba Arizona Pain Care Center

Arizona Pain Care Center
HIPPA and Privacy Information

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).

With my consent, Arizona Pain Care Center (AZPCC) may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). Please refer to AZPCC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. AZPCC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at AZPCC, 12480 N. Rancho Vistoso Blvd., Suite 180, Oro Valley, Arizona 85755. With my consent, AZPCC may call my home or designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items that assist the practice in carrying out TPO, such as appointment reminder cards, and patient statements as long as they are marked Personal or Confidential.

I have the right to request that AZPCC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting AZPCC use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, AZPCC may decline to provide treatment to me.

NOTE: Quality healthcare is partnership between patient and provider. Should you require further testing, imaging studies or return visits to monitor your well-being, you must assume responsibility of following through. If for some reason you do not agree with the tests requested, please show us the courtesy of communicating this concern.

______________________________	______________________________
Print Name of Patient or Legal Guardian	Date
______________________________	______________________________
Signature of Patient or Legal Guardian	Name of Patient (if different)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received a copy of the office's Notice of Privacy Policies

______________________________	______________________________
Patient or Legal Authorized Signature	Relationship to Patient

Lifetime Insurance Assignment and Authorization Form

Arizona Pain Care Center is pleased to file insurance for our patients. In order to correctly process your insurance claims, the patient or responsible party is responsible for providing, at the time of service, the most current address, phone number and insurance information.

I authorize payment directly to Arizona Pain Care Center, of benefits otherwise payable to me by my insurance company(ies). I do hereby assign, set over and transfer to Arizona Pain Care Center my right to proceeds from any insurance company who is or may be liable at any time for all or part of my charges on this account to the extent necessary to pay such charges in full. If my insurance does not pay Arizona Pain Care Center directly, I agree to pay Arizona Pain Care Center amounts equal to all health insurance benefits which I receive for medical care at Arizona Pain Care Center immediately upon receipt of such payments.

I authorize Arizona Pain Care Center to release to my insurance carrier or it's representative any information needed from my medical records concerning the examination or treatment rendered to me that is necessary to process an insurance claim.

______________________________ ______________________________ ________________

Patient Name Signature * Date

*If patient is under 18 and unmarried, parent / guardian must sign below

______________________________ ______________________________ ________________

Parent / Guardian Signature * Date

Statement of Financial Responsibility

I acknowledge I am responsible for all charges for Arizona Pain Care Center, services provided to me, whether incurred in the past or future, including any amount not paid and/or not covered by my insurance or other third-party payors, excluding contractual insurance adjustments. I understand that Arizona Pain Care Center will not accept responsibility for collecting insurance or negotiating the settlement of a disputed insurance claim. I agree to pay the charges for care provided to the patient by Arizona Pain Care Center within sixty (60) days of the date of the first monthly bill. Any account not paid in full within sixty (60) days of the date of the first monthly bill is considered delinquent. Should collection action become necessary, I agree to pay reasonable attorney's fees, expenses and court costs incurred by Arizona Pain Care Center.

I have read and understand the terms stated above. These terms and conditions constitute my complete agreement and may be modified only by written agreement signed by an authorized official of Arizona Pain Care Center. I acknowledge receipt of a copy of this agreement.

______________________________ ______________________________ ________________

Account Responsible Party Signature Date

______________________________ ______________________________ ________________

Account Responsible Party Signature Dat

OPIOID RISK TOOL (ORT)

How do I fill out the Opioid Risk Tool?

First: Identify the column on the right with your gender.
Second: Circle the number corresponding to the category if any of the items apply to you.

If an item on this tool doesn't apply to you, leave it blank. A member of our staff will score the tool accordingly. At Arizona Pain Care Center, we require ALL of our patients to fill this out to establish care with our physicians, as medication could become part of your pain management program with our providers.

		Female	Male
1. Family History of Substance Abuse	Alcohol	1	3
	Illegal Drugs	2	3
	Prescription Drugs	4	4
2. Personal History of Substance Abuse	Alcohol	3	3
	Illegal Drugs	4	4
	Prescription Drugs	5	5
3. Age (circle number if your current age is 16-45 years old)		1	1
4. History of Preadolescent Sexual Abuse		3	0
5. Psychological Disease			
	Depression	1	1
Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia		2	2
6. Scoring total		______	______

What is the Opioid Risk Tool?
A brief, self-report screening tool designed for use with adult patients to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain.

What is the research behind the Opioid Risk Tool?
Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid rise too. Pain Med. 2005; 6(6):432. Additional information may be found at the following websites: www.drugabuse.gov and www.azdhs.gov

EASI-sa

Within the last 12 months: (this form is intended for patients 65 years and over)

1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?
   YES NO
2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with?
   YES NO
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?
   YES NO
4) Has anyone tried to force you to sign papers or to use your money against your will?
   YES NO
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?
   YES NO

The EASI was developed to raise a doctor's suspicion about elder abuse to a level at which it might be reasonable to propose a referral for further evaluation by social services, adult protective services, or equivalents. While all six questions should be asked, a response of "yes" on one or more of questions 2-5 may establish concern. The EASI was validated for asking by family practitioners of cognitively intact seniors seen in ambulatory settings. Yaffe MJ, Wolfson C, Lithwick M, Weiss D. Development and validation of a tool to improve physician identification of elder abuse: The Elder Abuse Suspicion Index (EASI) ©. Journal of Elder Abuse and Neglect 2008; 20(3) 000-000. In Press. Haworth Press Inc: http: //www.HaworthPress.com © The Elder Abuse Suspicion Index (EASI) was granted copyright by the Canadian Intellectual Property Office (Industry Canada) February 21, 2006. (Registration # 1036459)

Confidential Communication Request and Contact Preferences (HIPAA Form)

To best serve our patients, there are times when it may be necessary to leave a detailed message on a voicemail (i.e. an imaging result, an update on a medication dosage, a procedure clarification, or details about an upcoming procedure). In addition, it may be necessary to give this information to a trusted family member. Please read and fill out the following choices so that the staff of Arizona Pain Care Center can best serve your pain care needs.

Please CIRCLE the number of one of the following three choices:

1. Ok to leave a phone message with detailed health information at the following phone number:
   (______)________________________
2. Ok to leave a phone message with a callback phone number only at the following phone number:
   (______)________________________
3. Do NOT leave a phone message at any number

In case we cannot reach you or you would like us to share your information with anyone else, please CIRCLE one of the following two choices for information sharing:

1. OK to disclose lab, radiology, test, or procedure results only
2. OK to discuss and disclose any/all clinical information

Please list the name, relationship to patient, and contact phone number for anyone who has our permission to share your information about your care:

NAME	RELATIONSHIP TO PATIENT	CONTACT PHONE NUMBER
1.		
2.		
3.		