

Pain Centers

7862 Kingland Drive Ste 201*West Chester, OH 45069
Phone (513) 755-1341 * Fax (513) 755-5342

New Patient Information

Name: _____ Hm. Phone: _____ Wk. Phone: _____ Cell: _____

Address: _____ email _____ Date of Birth _____

City/State/Zip: _____ SSN: _____ Male Female Age _____ Minor (under 18 yrs old)

Occupation _____ Employer _____

When is the best time to reach you _____ What Number is the best to reach you on _____

Referring Physician: _____ Phone#: _____ Whom may we thank for referring

you _____ In case of an emergency, who should be notified _____ Phone _____

Have you recently had MRI's or X-rays: Yes NO Where _____ When _____

Nearest Relative Not living w/ you: _____ Phone#: _____

Marital status Married Single Divorced Widowed

Spouse's Information

Spouse's Name: _____ Date of Birth _____

SSN _____ Employer _____ Wk Phone _____

Minor Information

Custodial Parent/Guardian Name _____

Address: _____ email _____

Hm. Phone: _____ Wk. Phone: _____ Cell: _____

Primary Insurance

Person Responsible for this Account _____ Relationship to patient _____

Address: _____ email _____

Subscriber Employed by _____ Wk Phone _____

Primary Insurance: _____ SSN _____

ID# _____ Group# _____

Whose name is the Insurance in/primary card holder _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____

Name of Insurance Company(ies)

And assign directly to **The Back & Spine Center of West Chester, Inc./West Chester Pain Management** all insurance benefits, if any, otherwise 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 the doctor(s) to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all Insurance submissions.

I have read and completed all information above. I certify this information is true and correct to the best of my knowledge. I will notify you of changes in my status on the above information.

Signature

Date

Parent/Guardian Signature

Date

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INFORMED CONSENT TO TAKE OPIATE/NARCOTIC PAIN MEDICATION

If your Doctor has determined that Opiate pain medication is indicated for treatment of your pain, this information is for you.

Opiate pain medications include: Percodan and Percocet , Oxycontin, and Roxycodone. (Schedule II) Lorcet, Lortab, Vicodin. (Schedule III) Generally schedule II medications have a greater potential for abuse and addiction, but are indicated if other medications have failed to control your pain.

As with any medical treatment there are risks and benefits to treatment with Opiate medications.

Benefits: Reduced pain, increased sleep, decreased fatigue, improved function at work, and increased mood and enjoyment of life.

Risks: Side effects such as constipation, sedation, nausea, vomiting, and itching are the most common side effects. A serious and potentially fatal side effect is respiratory depression. This usually only occurs at very high doses and in patients who take other drugs with additive effects such as tranquilizers or muscle relaxers or sleeping medicine. You are also at increased risk for respiratory depression if you have a respiratory condition such as asthma. It is important to tell your Doctor if you are taking any other medicines and if you have any other medical conditions when he takes your medical history. You must not use alcohol or any recreational drugs if you are taking opiate pain medicine as this can cause potentially fatal respiratory depression. You must also inform your Doctor if you have liver, kidney, or Gastrointestinal problems Opiate pain medications can be dangerous or even fatal in some of these conditions.

Tolerance: You may develop tolerance to Opiate medications. This means that you will need to increase the dose in order to continue to get pain relief. You should never do this on your own. If the medication is not working you must inform your Doctor and he will adjust the dose. After 4 months-6 months of treatment your Doctor will attempt to lower the dose of medication and wean you slowly from medication. You should never stop medication suddenly as this may precipitate a syndrome known as withdrawal. This can be uncomfortable with rapid heart beat shaking sweating, or more serious including the development of convulsions or death. If you experience withdrawal symptoms call your Doctor and proceed to the Emergency room or call 911.

Addiction: Certain patients are psychologically prone to addiction, which is not the same as tolerance. Addiction is psychosocial dependence on the medication for reasons other than pain management. If you have ever had a substance abuse problem or been treated for a psychiatric condition it is important to tell your Doctor this when he takes your history. You will be referred to the appropriate specialist in this case.

Sedation: If your work requires you to operate hazardous machinery or be in a state of optimum concentration be aware that Opiate medication can cause sedation and decreased concentration. Do not participate in hazardous activities until you and your Doctor have assessed the medication effect on you and you are familiar with them.

Alternative Forms of Treatment: Other medications such as Nonsteroidal antiinflammatories (ADVIL VIOX Etc.), muscle relaxers, and anti anxiety medications. Physical therapy and modalities (heat, ice, ultrasound, rehabilitative exercises etc.) are all forms of treatment that can be used. Each carries its own risks and benefits, which have been explained by your Doctor. It is generally recommended that your pain management program include Physical Therapy where possible and often other medication are used as a adjunct to Opiate pain medication. Opiate pain medication is indicated where these alternative forms of therapy alone have failed to control your pain.

I have read the preceding page regarding risks, benefits of the proposed treatment and have been given an explanation of these as well as alternative forms of treatment. I understand these and have had ample time to discuss these with my Physician.

Patient's Signature

Date

Physician's Signature

Date

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Pain Management Agreement

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

I understand only one doctor can prescribe controlled substances for a patient. The patient identifies one doctor to the prescribed medication. All other doctors caring for this patient must be told about this plan. I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, from any other doctor.

In Ohio, it is a felony to change a prescription in any way. We will allow the authorities to seek the greatest sentence the law allows if this happens. If there is a sign a prescription is being sold, we will report this to the Narcotics division Unit of the West Chester Police Department.

I understand if I am verbally or physically abusive to any staff member or engage in any illegal activities as described in this agreement; the incident may be reported to other physicians, pharmacies, other authorities as deemed appropriate. This depending upon the incident, this could result in dismissal from this office.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, etc. I will not share, sell or trade my medication with anyone. I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced. I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

I agree to use _____ Pharmacy, Located at _____

Telephone # _____, for filling prescriptions for all of my pain medicine.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine. I will bring all unused pain medicine to every office visit. I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time. Further, this is grounds for dismissal. I agree that I will only take any/all medications as directed by my physician. Taking too much medication (without physician approval) is grounds for dismissal.

I recognize that my pain represents a complex problem, which may benefit from physical/rehab therapy, psychotherapy, chiropractic, behavioral medicines, and other pain control strategies. I agree to cooperate and actively participate in all aspects of the pain management program to maximize function and to improve coping with my condition. If recommended by the doctor it is expected to be followed through and to be compliant with the outlined care plan from your provider. I understand that I have a right to refuse any procedure, but that does not mean that my provider must continue to prescribe narcotic or opioid medication.

I understand that if I break this Agreement, my doctor will stop prescribing these pain-control medicines and I will be dismissed. I agree to random pill counts in which I will arrive to the clinic within 60 minutes

In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this

(Date)

(Patient signature)

(Staff/Witness)

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Patient Name: _____

Relation	Age	State of Health	Age at Death	Cause of Death	Check if, Your blood relatives had any of the following	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Number of pregnancies _____

Year	Sex	Complications, if any

Health Habits

Have you ever had a blood transfusion? Yes or NO If yes When?

Date	Serious Illness/Injury	Outcome

Check which you use and how much

	Caffeine	
	Tobacco	
	Drugs	
	Alcohol	

Occupational

Occupation: _____

Check if you work exposes you to the following

Stress	Hazardous Substances
Heavy Lifting	Other

Medications:

Allergies:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form:

Signature _____

Date _____

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REVIEW OF SYSTEMS

Name		Date	Birth Date	SSN #
Height	Weight	BWC Claim Number	Pharmacy Name & Phone Number	

Please check all that apply.

GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

EYES, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Ear-ache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision flashes
- Vision halos

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

MUSCLE/JOINT/BONE

- Pain, weakness, numbness in:
- Arms
- Back
- Feet
- Hands
- Hips, Legs
- Neck
- Shoulder

CARDIOVASCULAR

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

SKIN

- Bruise easily
- Hives
- Itching
- Changes in moles
- Rash
- Scars
- Sore that won't heal

MEN ONLY

- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis

G-I

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

WOMEN ONLY

- Abnormal pap smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Other

Date of last menstrual period
Date of last pap smear
Have you had a mammogram?
Are you pregnant?
Number of children

CONDITIONS - Please check all that apply

- Aids
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts
- Chemical Dependent
- Chicken Pox
- Diabetes
- Emphysema

- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart disease
- Hepatitis
- Hernia Herpes
- High Cholesterol
- HIV positive
- Kidney disease
- Liver disease
- Measles
- Migraine headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps

- Pacemaker
- Pneumonia
- Polo
- Prostate problems
- Psychiatric care
- Rheumatic fever
- Scarlet fever
- Stroke
- Suicide attempt
- Thyroid problems
- Tonsillitis
- Tuberculosis
- Typhoid fever
- Ulcers
- Vaginal infections
- Venereal disease

West Chester Pain Management

Notice of Privacy Practices

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

West Chester Pain Management (the "Practice"), in accordance with the federal Privacy Rule, 45 CFR parts 160 and 164 (the "Privacy Rule") and applicable state law, is committed to maintaining the privacy of your protected health information ("PHI"). PHI includes information about your health condition and the care and treatment you receive from the Practice and is often referred to as your health care or medical record. This Notice explains how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Practice, in accordance with this Notice and without asking for your express consent or authorization, may use and disclose your PHI for the purposes of:

(a) **Treatment** – To provide you with the health care you require, the Practice may use and disclose your PHI to those health care professionals, whether on the Practice's staff or not, so that it may provide, coordinate, plan and manage your health care. For example, a chiropractor treating you for lower back pain may need to know and obtain the results of your latest physician examination or last treatment plan.

(b) **Payment** – To get paid for services provided to you, the Practice may provide your PHI, directly or through a billing service, to a third party who may be responsible for your care, including insurance companies and health plans. If necessary, the Practice may use your PHI in other collection efforts with respect to all persons who may be liable to the Practice for bills related to your care. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(c) **Health Care Operations** – To operate in accordance with applicable law and insurance requirements, and to provide quality and efficient care, the Practice may need to compile, use and disclose your PHI. For example, the Practice may use your PHI to evaluate the performance of the Practice's personnel in providing care to you.

OTHER EXAMPLES OF HOW THE PRACTICE MAY USE YOUR PROTECTED HEALTH INFORMATION

(a) **Advice of Appointment and Services** – The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminders may be used by the Practice: a) a postcard mailed to you at the address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone.

(b) **Directory/Sign-In Log** – The Practice maintains a sign-in log at its reception desk for individuals seeking care and treatment in the office. The sign-in log is located in a position where staff can readily see who is seeking care in the office, as well as

the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

(c) **Family/Friends** – The Practice may disclose to a family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

(i) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.

(ii) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

OTHER USE & DISCLOSURES WHICH MAY BE PERMITTED OR REQUIRED BY LAW

The Practice may also use and disclose your PHI without your consent or authorization in the following instances:

(a) **De-identified Information** – The Practice may use and disclose health information that may be related to your care but does not identify you and cannot be used to identify you.

(b) **Business Associate** – The Practice may use and disclose PHI to one or more of its business associates if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies.

(c) **Personal Representative** – The Practice may use and disclose PHI to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) **Emergency Situations** – The Practice may use and disclose PHI for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible: The Practice may also use and disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) **Public Health Activities** – The Practice may use and disclose PHI when required by law to provide information to a public health authority to prevent or control disease.

(f) **Abuse, Neglect or Domestic Violence** – The Practice may use and disclose PHI when authorized by law to provide information if it believes that the disclosure is necessary to prevent serious harm.

(g) **Health Oversight Activities** – The Practice may use and disclose PHI when required by law to provide information in criminal investigations, disciplinary actions, or other activities relating to the community's health care system.

(h) **Judicial and Administrative Proceeding** – The Practice may use and disclose PHI in response to a court order or a lawfully issued subpoena.

(i) **Law Enforcement Purposes** – The Practice may use and disclose PHI, when authorized, to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena, or if the Practice believes that your death was the result of criminal conduct.

(j) **Coroner or Medical Examiner** – The Practice may use and disclose PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(k) **Organ, Eye or Tissue Donation** – The Practice may use and disclose PHI if you are an organ donor to the entity to whom you have agreed to donate your organs.

(l) **Research** – The Practice may use and disclose PHI subject to applicable legal requirements if the Practice is involved in research activities.

(m) **Avert a Threat to Health or Safety** – The Practice may use and disclose PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(n) **Specialized Government Functions** – The Practice may use and disclose PHI when authorized by law with regard to certain military and veteran activity.

(o) **Workers' Compensation** – The Practice may use and disclose PHI if you are involved in a Workers' Compensation claim to an individual or entity that is part of the Workers' Compensation system.

(p) **National Security and Intelligence Activities** – The Practice may use and disclose PHI to authorized governmental officials with necessary intelligence information for national security activities.

(q) **Military and Veterans** – The Practice may use and disclose PHI if you are a member of the armed forces, as required by the military command authorities.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

YOUR RIGHTS

You have the right to:

(a) Revoke any Authorization or consent you have given to the Practice, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request special restrictions on certain uses and disclosures of your PHI as authorized by law. In general, this relates to your right to request special restrictions concerning disclosures of your PHI regarding uses for treatment, payment and operational purposes under Privacy Rule, Section 164.522(a) and restrictions related to disclosures to your family and other individuals involved in your care under Privacy Rule, Section 164.510(b). Except in certain instances, the Practice may not be obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

(c) Receive confidential communications or PHI by alternative means or at alternative locations as provided by Privacy Rule Section 164.522(b). For instance, you may request all written communications to you marked "Confidential Protected Health Information." You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and copy your PHI as provided by federal law (including Privacy Rule, Section 164.524) and state law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

(e) Amend your PHI as provided by federal law (including Privacy Rule, Section 164.526) and state law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by federal law (including Privacy Rule Section 164.528) and state law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the Practice may charge you for the cost of providing additional lists. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

(g) Receive a paper copy of this Privacy Notice from the Practice (as provided by Privacy Rule Section 164.520(b)(1)(iv)(F)) upon request to the Practice's Privacy Officer.

(h) Complain to the Practice or to the Secretary of HHS (as provided by Privacy Rule Section 164.520(b)(1)(vi)) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions you want answered about your privacy rights (as provided by Privacy Rule Section 164.520(b)(2)(vii)), you may contact the Practice's Privacy Officer as follows:

Dr. M. Dolores Graf
7862 Kingland Dr.
West Chester, OH 45069
513-755-1341

HIPAA

Privacy Practice Notice

The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of 04/15/03.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient Date
Saved as hipa under forms in g-drive