Pain Medicine Specialists of Arkansas

GUIDELINES FOR PAIN MANAGEMENT PATIENTS

- Patients need to produce any MRI, CT or x-ray reports that have been done as well as any medical records that pertain to the medical need for pain management, including records from any physician seen in the previous six months.

- Each patient will be required to come into the office for a random drug screen or pill count if requested. Failure to respond to requests for random drug screen or pill counts may result in termination.

- Each patient shall bring their pain medications in their pharmacy bottle to **each and every** office visit.

- It is imperative that you provide us with a working phone number and have your voice mail set up. Inability to contact you for random drug screens, pill counts, or any other reason may result in termination from the pain management program.

- The physician or nurse practitioner may request the patient to be accompanied to their appointment by an immediate family member such as mother, father, sister, brother or another responsible individual. The reason for this is so the physician can discuss with the immediate family (in the presence of the patient) the patient's behavior and mannerisms while at home and performing their daily duties.

Patient Signature: _____ Date: _____

1225 Breckenridge Drive, Suite 106, Little Rock, AR 72205
Phone: (501) 451-2500 Fax: (501) 451- 4801

Pain Medicine Specialists of Arkansas

CANCELLATION AND MISSED APPOINTMENT POLICY

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner.

Text and Email Reminders

We do send text and email reminders for appointments, however; it is still your responsibility to keep up with your appointment date and time. Not receiving a reminder is not an excuse for missing an appointment.

Please check your preference:

Text Reminder____

Email Reminder____

Both____

Cell phone: _____

Email: _____

Cancellation of an Appointment

Please be courteous and call the clinic promptly if you are unable to show up for an appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance.

How to Cancel Your Appointment or Procedure

To cancel appointments or a procedure scheduled, please call 501-451-2500. If you do not reach the receptionist, you may leave a detailed message on our voicemail. If you would like to reschedule your appointment, please leave your phone number.

Late Cancellations:

A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24-hour advance notice.

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Phone: (501) 451-2500 Fax: (501) 451- 4801

Office Visit No Show:

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present **at the time** of a scheduled appointment will be recorded in your medical record as a "no-show."

- First missed appointment: $25 fee will be billed to your account and must be paid prior to next appointment.
- Second missed appointment: $25 fee will be billed to your account and must be paid prior to next appointment.
- Third missed appointment: $75 fee will be billed to your account and **you may be discharged from our practice.**

Procedure Date No Show:

Patients may need a procedure done that is performed at a different site than PMSA's office. PMSA utilizes different ambulatory surgical centers in Little Rock for these procedures in addition to PMSA's office. A "no-show" to a procedure date by a patient also incurs fees. A failure to be present **at the time** of a scheduled procedure, whether that is at a surgery center or PMSA's office, will be recorded in your medical record as a "no-show."

- All "no-shows" for a patient's procedure date will be a $100 fee billed to your account which must be paid prior to your next appointment.

If you have any questions about these policies, please ask our office.

Acknowledgment: I have read and understand the above policy.

Patient Signature: _____Date:

PMSA

ASSIGNMENT OF INSURANCE BENEFITS/ELIGIBILITY CERTIFICATION

Primary Insurance Plan		
Patient Name	Date of Birth	
Insurance Plan	Group #	Policy #
Insurance Company Address	Phone #	
Subscriber Name	Relationship to Patient	
Subscriber Certificate/Social Security #	Subscriber Date of Birth	
Subscriber Employer	Employer Phone #	
Employer Address		
For Medicare Patients Only		
Health Insurance Claim #	Part A Effective Date	Part B Effective Date
Other Insurance Coverage for Patient		
Patient Name	Date of Birth	
Insurance Plan	Group #	Policy #
Insurance Company Address	Phone #	
Subscriber Name	Relationship to Patient	
Subscriber Certificate/Social Security #	Subscriber Date of Birth	
Subscriber Employer	Employer Phone #	
Employer Address		

☐ hereby authorize and request that payment of authorized Medicare/other insurance company benefits be made on my behalf and be paid directly to Meridian Medical for any medical or surgical services rendered to me or a member of my family. I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its agents or carriers, or the insurance company any information needed for this or a related Medicare/other insurance claim to determine these benefits or the benefits payable for related services. I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment.

Signature of Patient/Responsibility Party

Date

Name of Patient/Responsible Party (Please Print)

Relationship to Patient

Pain Management Agreement

This pain management agreement (sometimes "this agreement") is entered into on this _____day of _____by and between Julio Olaya, M.D., an Arkansas medical doctor, (herein "Dr. Olaya) and _____("patient"). This agreement shall become effective as of the date of its signing and shall be effective until it is superseded with the execution of a new pain management agreement dated after the date of this agreement.

Whereas the undersigned patient desires to receive treatment for chronic pain, patient agrees to strictly abide by all of the rules set forth at this facility whether the rules are in effect at the present time or are hereafter enacted. Patient understands that this agreement is essential to the trust and confidence necessary in a doctor-patient relationship and that patient's doctor must be able to trust patient in order to be able to lawfully and effectively treat patient's chronic pain. Patient further agrees to strictly comply with each of the following terms and conditions:

1. Patient will be completely honest with all members of Dr. Olaya's staff, including the Advanced Practice Registered Nurse (APRN), medical assistants, lab personnel, receptionists, office manager and all other employees. Patient will truthfully answer all questions asked by members of Dr. Olaya's staff. Patient will:

    a) not make any statement to any member of Dr. Olaya's staff that patient does not believe to be completely truthful, and
    b) disclose all information to Dr. Olaya that patient believes Dr. Olaya, or his employee(s) or assistant(s) should know to be able to treat patient's medical condition(s), including treatment for pain, even if patient is not specifically asked for such information.

2. Patient warrants that he or she suffers from chronic pain, which is pain that has lasted longer than six months. The pain that patient suffers interferes with activities of daily living. If patient sustains any injury or has any health issue which causes a new onset of pain. Patient agrees to promptly notify Dr. Olaya about the new onset of pain.

3. Patient will keep all scheduled appointments with Dr. Olaya. If patient misses a scheduled appointment patient may be charged and agrees to pay a fee established by Dr. Olaya in an amount not to exceed the regular charge for an office visit. Patient agrees to pay such visit prior to the next scheduled office appointment or treatment.

4. Patient agrees to bring all paperwork and medical records that are requested by any staff member of Dr. Olaya or that patient knows or believes will clarify the necessity for pain management by Dr. Olaya.

5. Patient will immediately notify Dr. Olaya if patient believes that medication prescribed by Dr. Olaya is causing adverse side effect upon patient. Adverse side effects may include, but are not limited to: intoxication, drowsiness, sedation, dizziness, euphoria, hallucinations, delirium, sweating, constipation, irritability, respiratory distress or difficulty or any other condition that causes distress to patient. Patient understands that while uncommon, life-threatening side effects such as slow or shallow breathing or not breathing at all can occur when taking opioids even as directed.

6. Patient will not use, buy, sell or possess any drug or narcotic that patient is not lawfully entitled to use, buy, sell or possess. Patient will immediately notify Dr. Olaya if patient is directly or indirectly involved in the unlawful use, buying, selling or possession of any drug or narcotic.

7. Patient will notify Dr. Olaya, both orally and in writing, if patient is arrested for or charged with any felony offense or any offense involving the use, sale, or possession of any lawful or unlawful drug or narcotic. As used throughout this agreement, the term "drug or narcotic" includes marijuana, methamphetamines, cocaine, heroin, or any drug or narcotic which requires a physician's prescription to obtain.

8. Patient will not share, sell, trade or give away any medication that is prescribed by Dr. Olaya. Patient understands that such actions are unlawful and may subject patient to criminal prosecution. Patient has been notified that even giving away a

single dose of medication prescribed by Dr. Olaya or any other doctor to a family member or anyone else, even someone in pain, is a violation of applicable law and of the terms of this pain management agreement.

9. Patient will not be involved in any disturbances in or around the facilities or offices utilized by Dr. Olaya.

10. Patient agrees that Dr. Olaya will be the only prescriber for any drug or narcotic used to treat pain. Patient will not request or receive a prescription for (or actually receive delivery of) any medication or drug or narcotic that may be used to treat chronic pain from any other medical doctor, osteopathic doctor, dentist, hospital, person or other medical provider unless such medication is received during treatment at a duly licensed hospital. Patient understands that patient may not leave any hospital with any medication or prescription for medication used to treat pain unless such medication has been prescribed by Dr. Olaya or an emergency requires that such medication be used and Dr. Olaya is notified within twenty-four hours after leaving the hospital or as soon thereafter as is reasonably practical.

11. Patient agrees to use medications as instructed by Dr. Olaya. Patient will not take any medication for the treatment of pain at an amount or rate that is in excess of that prescribed by Dr. Olaya. Patient agrees that if patient is instructed to avoid taking any other controlled substances or prescription medications that patient will completely refrain from taking such other controlled substances or prescription medication. Patient agrees that if patient is instructed to avoid using alcoholic beverages that patient will completely refrain from using or consuming such items or substances.

12. Patient agrees to attend Nurse Counseling visit annually and participate in naloxone training. Patient will fill prescription for naloxone and keep it readily available in case of an opioid emergency affecting patient or others who may be exposed to patient's opioids.

13. Patient will share signs and symptoms of an opioid emergency, such as slowed or stopped breathing with family members and friends. Patient will instruct family

members and friends on the proper use of naloxone. Patient understands that naloxone does not replace emergency medical attention and will alert family members and friends to contact emergency medical assistance (calling 911) in addition to administering naloxone during a suspected or known opioid emergency.

14. Patient will safeguard all medication from loss and theft. Patient understands that prescriptions for lost or stolen medication will not be rewritten or reissued.
15. Patient will provide Dr. Olaya a written account of all medications prescribed by other providers at every visit. Failure to provide Dr. Olaya with an accurate list of medications may result in an abnormal urine drug screen report. Patient understands that Dr. Olaya monitors all controlled substance prescriptions via the Arkansas Prescription Monitoring Program, and if patient fills narcotic pain prescriptions from other providers patient may be terminated from the pain management program.

16. Patient agrees to submit, at patient's expense, to a complete analysis of blood or urine, or both, at each monthly appointment.

17. Patient agrees to promptly (within 24 hours) submit to any requests made by Dr. Olaya for a random medication pill count or urine drug screen. Patient agrees to pay for the cost of urine drug screens. Patient agrees that Dr. Olaya may request a random pill count or urine drug screen at any time, whether Dr. Olaya has a specific reason to request such pill count or drug screen. Failure to comply with random pill counts or urine drug screens may result in termination from the pain management treatment program. In addition to any random pain medication pill count, Patient agrees to bring their pain medication to **every** office visit with Dr. Olaya.

18. Patient authorizes Dr. Olaya and his associates and staff to provide patient's medical records and other confidential information concerning patient's treatment to other physician offices, hospitals, medical providers, medical facilities, pharmacies, state medical board (or its equivalent), state or federal agency or board, or any law enforcement office or agency, if:
    a) Dr. Olaya is requested to do so by the Arkansas State Board or Medicine (including any agent, attorney, or officer acting on its behalf) or any law enforcement officer or agency

b) Dr. Olaya reasonably determines such action is necessary to ensure patient's compliance with these terms and conditions.

This authorization granted to Dr. Olaya and the consents specified in this section shall survive the expiration of this agreement and the termination of the doctor-patient relationship existing between Dr. Olaya and patient if information or medical records concerning patient are requested by the Arkansas State Board of Medicine or by any law enforcement officer or agency.

19. Patient will promptly notify Dr. Olaya if patient's address or telephone number changes. Failure to provide accurate contact information may result in termination from the pain management treatment program.

20. Patient will not associate with any person who has been arrested for or convicted of the unlawful purchase, use, selling, manufacturing, dispensing or possession of any drug or narcotic unless patient notifies Dr. Olaya in writing and receives advance permission to associate with such person.

21. Patient understands that any references to "medications prescribed by Dr. Olaya" in this agreement includes any medications prescribed by Dr. Olaya even if such medication was prescribed outside of a regular office visit.

22. Patient will immediately notify Dr. Olaya, both orally and in writing, if patient violates any of these terms and conditions, even if such violation occurs through mistake, inadvertence, accident, unintentionally or otherwise.

23. Patient will immediately notify Dr. Olaya, both orally and in writing, if patient becomes aware of any other patient of Dr. Olaya violating any of these terms and conditions.

24. Patient agrees and understands that if patient violates any of these terms and conditions that patient may be terminated as a patient of Dr. Olaya without advance notification.

25. If any portion of this agreement is deemed to be invalid or unlawful, the remainder shall be severable, valid and effective as if such invalid or unlawful portion was not a part of this agreement.

26. Patient has read and understood each of these terms and conditions. If patient has any question regarding these requirements or their interpretation patient agrees to immediately notify Dr. Olaya. Any question that patient currently has about these terms and conditions is set forth here:

_____

_____

If these lines are left blank, then patient has no questions about these requirements.

Patient Signature: _____ Date: _____

Physician Signature:_____ Date: _____

Pain Medicine Specialists of Arkansas

PAIN MANAGEMENT RULES AND POLICIES

Please refer to your Pain Management Agreement for a more detailed breakdown of your obligations as a patient. The rules and policies included below are in addition to the ones included in your Pain Management Agreement.

- Pain medications WILL NOT be filled any sooner than your appointment or refill date. Please schedule your vacations and out of town trips with this in mind.
- Prescriptions are written for a maximum of 30 days of medication.
- Lost or stolen medications or prescriptions will NOT be replaced. Please keep your medications in a safe and secure location.
- You must only use one pharmacy to fill all your prescriptions. If you change pharmacies, a new Pain Management Agreement will need to be filled out and signed.
- Pain medications in its pharmacy bottle **MUST** be brought to **every** office visit.

Your pharmacy choice is: _____

Location: _____

- If for any reason you present to an emergency department/room, you must inform them of your Pain Management Agreement with Pain Medicine Specialists of Arkansas. Within 48 hours of your emergency department/room visit, you must inform Pain Medicine Specialists of Arkansas and provide us with your discharge paperwork.

Signature: _____

Date: _____

1225 Breckenridge Drive, Suite 106, Little Rock, AR 72205
Phone: (501) 451-2500 Fax: (501) 451-4801

Pain Medicine Specialists of Arkansas

FINANCIAL POLICY

In order for our office to deliver the quality of care that you are accustomed to, we have established financial policies.

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

1. We ask that you present your insurance card(s) at each visit. It is your responsibility to provide us the correct information to bill your insurance.

2. If you have a change of address, telephone numbers, or employer, please notify the receptionist.

3. We will collect your co-payment, charges from previous visits, and charges for non-covered services at the time of your visit. We accept cash, checks, and Visa, MasterCard, Discover, AMEX and debit cards.

4. Your account will be charged a fee for returned checks for non-sufficient funds.

5. By Federal Law and Managed Care Contract law, this office is required to collect co-payments at the time of service. If you do not pay your co-payment, you will be charged a delinquent co-payment fee.

6. If your insurance denies our charges or does not pay us in a timely manner, you will be responsible for the charges.

7. If your account becomes delinquent, we reserve the right to refer your account to a collection agency and report it to a credit bureau.

8. MEDICARE PATIENTS: We are participating providers with Medicare and will bill Medicare for all of your covered charges. We will also bill any secondary insurance you may have. If you do not have a secondary insurance, any remaining balance will be your responsibility. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.

9. HMO-PPO PATIENTS: If we participate with your plan, we will bill your insurance for you. If your plan requires you to choose a primary care physician, it is your responsibility to notify your plan. If your plan requires you to have an authorization to see a specialist you will need to obtain that from

our office prior to seeing the specialist. No retroactive referrals will be given. If we do not participate with your plan, we will attempt to bill your insurance. Any amount remaining from your out-of-network benefits will be your responsibility to pay.

10. SELF-PAY PATIENTS: Patients with no insurance will be expected to pay at the time of service. If you are not able to pay in full, you will need to contact our billing department to discuss payment arrangements prior to being seen.
11. MEDICAID PATIENTS: We are contracted with traditional Medicaid and some Medicaid HMO plans. If we are contracted with your plan, we will submit your claims. If we are not contracted with your plan, we will not submit your claim and you will be considered self-pay and are liable for payment of all services provided. Services may be a covered Medicaid service and other providers may render the service at no cost to you. In the future if you choose to utilize your Medicaid plan you agree to transfer care to a Medicaid provider. Patients that miss an appointment will be discharged from the practice.
12. When an appointment is scheduled, that time is specifically allocated for you. When an appointment is not canceled in advance, we consider this a "no-show". We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel your appointment at least 24 hours ahead. You will be charged a $25 dollar fee for your first "no-show." A $25 fee for the second "no-show." A $75 dollar fee for your third "no-show" and you may be discharged from our practice.
13. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. It is very important that you understand the provisions in your policy. We cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, this becomes your financial obligation.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing department at 479-968-4273.

By signing below, you are attesting that you have read and have a full understanding of the financial policy of **Pain Medicine Specialists of Arkansas.**

Printed Name:_____ Date of Birth:

Signature/Legal Guardian:_____ Date:

Patient Registration Form

Patient Information (Please Print)

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip Code

Gender ☐ M ☐ F	Social Security	Preferred Language	Driver's License
Home Phone	Work Phone	Cell Phone	
Other Name(s) Used	E-Mail Address		

Marital Status	Preferred Contact	Ethnicity	Race
Married	Mail	Cambodian	American Indian or Alaskan Native
Single	Home Phone	Filipino	Asian
☐ Divorced	☐ Work Phone	☐ Hispanic/Latino	☐ Black or African American
☐ Separated	☐ Mobile Phone	☐ Non-Hispanic	☐ Native
☐ Widowed	☐ E-Mail	☐ Other	☐ White
Life Partner	☐	☐	☐ Other

Primary Care Physician	Referring Physician

Responsible Party (Guarantor)

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip Code

Relationship to Patient	Social Security	Preferred Language	Driver's License
Home Phone	Work Phone	Cell Phone	

Emergency Contact

First Name	Last Name	MI	Relationship
Address	City	State	Zip Code
Home Phone	Work Phone	Cell Phone	

I/we do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of Meridian Medical to me or to the above named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained herin are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Meridian Medical to release information requested by insurance company and/or its representatives. I grant permission to Meridian Medical or its vendors to contact me with an automated dialer. I fully understand this agreement and this consent will continue until cancelled by me in writing.

Signature Printed Name Relationship to Patient Date

Patient Registration Form

Pharmacy Information

Preferred Pharmacy		Secondary Pharmacy	
Name		Name	
Address		Address	
Phone	Fax	Phone	Fax

Advanced Directives

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ Healthcare Proxy

Date Reviewed: _____

Medications - List all medications you take, prescription and non-prescription and the dosage

☐ I do not take any medications

Medication Name	Dosage

Medication and Food Allergies - List all known allergies (drugs, food, animals etc)

☐ No Known Allergies

Drug, Food or Animal	Reaction (rash, hives, trouble breathing)

Social History

Occupation		Employer			
Do you have children?	☐ Yes	☐ No	How Many?	Female(s)	Male(s)

Tobacco Use ☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year Quit	☐ Chewing ☐ Pipe ☐ Smokeless ☐ Cigar ☐ Cigarette
Alcohol Use ☐ Yes ☐ No	Daily Weekly Less ☐ Former/Year Quit	☐ Beer ☐ Liquor ☐ Wine ☐ Other
Illicit Drug Use ☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year Quit	☐ Marijuana ☐ Heroin ☐ Other ☐ Cocaine ☐ Methamphetamine
Caffeine Use ☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year Quit	☐ Chocolate ☐ Soda ☐ Tablets ☐ Coffee ☐ Tea ☐ Other
Exercise ☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Less	☐ Cardio ☐ Strength

Medical History - Check if you have ever experienced the following conditions, and list the year of onset

Condition	Year	Condition	Year
☐ None		☐ Gallbladder Disease	
☐ Allergies		☐ GERD (Reflux)	
☐ Anemia		☐ Hepatitis	
☐ Angina		☐ Hyperlipidemia	
☐ Anxiety		☐ Hypertension	
☐ Arthritis		☐ Irritable Bowel Disease	
☐ Asthma		☐ Liver Disease	
☐ Atrial Fibrillation		☐ Migraine Headaches	
☐ Benign Prostatic Hypertrophy		☐ Myocardial Infarction (heart attack)	
☐ Blood Clots		☐ Osteoarthritis	
☐ Cancer		☐ Osteoporosis	
☐ Cerebrovascular Accident (stroke)		☐ Peptic Ulcer Disease	
☐ Coronary Artery Disease		☐ Renal (kidney) Disease	
☐ COPD (emphysema)		☐ Seizure Disorder	
☐ Crohn's Disease		☐ Thyroid Disease	
☐ Depression		☐ Other	
☐ Diabetes		☐ Other	

Surgical History - Check if you have received the following procedures and note the year performed

Surgical Procedure	Year	Surgical Procedure	Year
☐ None		Male Only	
☐ Angioplasty		☐ Prostate Biopsy	
☐ Angioplasty with stent		☐ TURP (Trans -urethral resection of prostate)	
☐ Appendectomy		☐ Vasectomy	
☐ Arthroscopy Knee		☐ Other	
☐ Back Surgery		☐ Other	
☐ CABG (heart bypass)			
☐ Carpal Tunnel Release		Female Only	
☐ Cataract Extraction		☐ Breast Augmentation	
☐ Cholecystectomy (gallbladder)		☐ Breast Biopsy	
☐ Colectomy		☐ Breast Reduction	
☐ Colostomy		☐ Cesarean Section	
☐ Gastric Bypass		☐ D and C	
☐ Hernia Repair		☐ Hysterectomy	
☐ Joint Replacement		☐ Mastectomy	
☐ LASIK		☐ Myomectomy	
☐ Liver Biopsy		☐ Tubal Ligation	
☐ Pacemaker		☐ Other	
☐ Small Bowel Resection		☐ Other	
☐ Thyroidectomy			
☐ Tonsillectomy			
Other			

Health Maintenance - check if you have received the following, and date of most recent exam

Exam	Date	Exam	Date
☐ None		Eye Exam	
☐ Breast Exam		Foot Exam	
☐ Cardiac Stress Test		Glucose test (blood sugar)	
☐ Chest X-Ray		GYN Exam	
☐ Colonoscopy		☐ Lipid Panel	
☐ Complete Blood Count		☐ Mammogram	
☐ Dental Exam		☐ PAP Test	
☐ DEXA Scan		☐ Physical Exam	
☐ Echocardiogram		☐ Pulmonary Function Test	
☐ EKG		☐ Sigmoidoscopy	
☐ Electrolye blood test		☐ TB Skin Test	

Immunizations - check if you have received the following, and date immunization received

Immunizations	Date	Immunizations	Date
☐ None		☐ MMR (Measles, Mumps, Rubella0	
☐ Diphtheria/Pertussis		☐ Pneumonia	
☐ Hepatitis A		☐ Polio	
☐ Hepatitis B		☐ Shingles	
☐ Influenza		☐ Tetanus Toxoid	
☐ Meningitis		☐ Other	

Family History - check if any family member(s) has had any of the following conditions

Diagnosis	Mother	Father	Brother	Sister	Maternal Grand mother	Maternal Grand father	Paternal Grand mother	Paternal Grand father
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Blood Disease	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hyperlipidemia (high cholesterol)	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension (high blood pressure)	☐	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Disease	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐
Osetoarthritis	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐
Peripheral Vascular Disease	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act-----45 CFR Parts 160 and 164)

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information (''PHI'') described below to my agent identified in my durable power of attorney for health care named Pain Medicine Specialists of Arkansas.

2. Authorization for release of PHI covering the period of health care (check one)
   a. ☐ from (date) _____ - to (date)_____ OR
   b ☐ all past, present and future periods.

3. I hereby authorize the release of PHI as follows (check one)**:**
   a. ☐ my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR
   b. ☐ my complete health record *with the exception of the following information* (check as appropriate):
      ☐ Mental health records
      ☐ Communicable diseases (including HIV and AIDS)
      ☐ Alcohol/drug abuse treatment
      ☐ Other (please specify): _____ .

4. In addition to the authorization for release of my PHI described in paragraphs 3 a and 3 b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

   Name _____ Relationship _____

   Name _____ Relationship _____

   Name _____ Relationship _____

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date: _____
Signature of Patient

Keep original, and give copies to your health care provider, agent and family members

Pain Medicine Specialists of Arkansas
1225 Breckenridge Drive, Little Rock, AR 72205

Privacy Officer
Marsha Melville
501-451-2500

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

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Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

July 1, 2016

This Notice of Privacy Practices applies to the following organizations.

Pain Medicine Specialists of Arkansas

Privacy Officer: Marsha Melville 501-451-2500

Pain Medicine Specialists of Arkansas

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of Pain Medicine Specialists of Arkansas' Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

1225 Breckenridge Drive, Suite 106, Little Rock, AR 72205
Phone: (501) 451-2500 Fax: (501) 451- 4801

Pain Medicine Specialists of Arkansas

- ☐ Communication barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____

_____

_____ _____

Signature of Office Personnel Date

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