Center for Interventional

PAIN & SPINE

WILLOW GROVE, PA	NEWARK, DE	WILMINGTON, DE	BRYN MAWR, PA	EXTON, PA	WEST GROVE, PA
P: 215-957-1108	P: 302-266-7800	P: 302-477-1706	P: 610-525-8200	P: 610-280-0360	P: 610-280-0360
F: 215-443-9318	F: 302-266-7851	F: 302-477-1708	F: 610-525-8201	F: 610-280-0181	F: 610-280-0181

INITIAL ASSESSMENT FORM

Name: _____

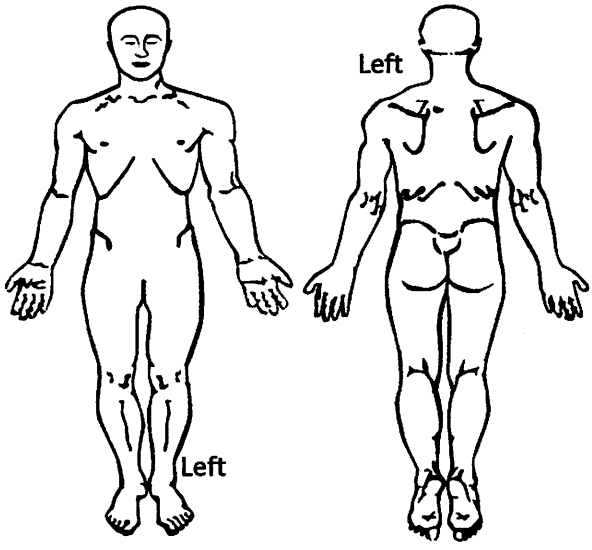
Date: _____

BP: _____/_____ HR: _____

Wt: _____ Ht: _____

Temp: _____

Location of pain: Please **shade** your area of pain



Please check what describes your pain:

☐ aching ☐ throbbing ☐ dull ☐ sharp ☐ stabbing
☐ shooting ☐ burning ☐ other:_____

Please check if you have associated symptoms:
☐ numbness ☐ tingling ☐ muscle spasm ☐ weakness
☐ bowel or bladder incontinence ☐ pins and needles

What worsens your pain? ☐ coughing ☐ straining ☐ standing
☐ bending ☐walking ☐ sitting ☐ driving ☐ touch
☐ cold ☐ Other: _____

What makes your pain better? ☐ rest ☐ cold ☐ warmth
☐sitting ☐ standing ☐ medication
☐ Other:_____

Indicate the one NUMBER between 0-10 that best describes your pain:

No pain *moderate pain* *severe pain* *unbearable*

0 1 2 3 4 5 6 7 8 9 10

_____ Pain at its worst _____ Pain at its least

_____ Average pain _____ Pain now

History of present illness: Is your injury ☐ work related or ☐ auto accident? Date of injury _____ State injury occurred _____

Describe the incident: _____

_____

_____

Review of systems

General
- ☐ fatigue
- ☐ fever
- ☐ weight loss/gain

Eyes
- ☐ vision loss

Head/Ears/Nose/Throat
- ☐ hearing loss
- ☐ nose bleed
- ☐ sore throat

Cardiovascular
- ☐ chest pain
- ☐ palpitations

Respiratory
- ☐ cough
- ☐ shortness of breath

Gastrointestinal
- ☐ vomiting blood

Genitourinary
- ☐ loss of bladder control

Musculoskeletal
- ☐ joint pain/swelling
- ☐ spasms
- ☐ weakness

Skin
- ☐ color changes

Neurological
- ☐ paralysis
- ☐ seizures

Psychiatric
- ☐ depressed mood
- ☐ hallucination

Endocrine
- ☐ elevated blood sugar

Hematology/Lymphatic
- ☐ bleeding
- ☐ bruising

Previous treatment

Did you have previous pain management? With who? _____ Treatments: _____

Did you have injections? ☐ No ☐ Yes, if so any relief? _____

Did you have any alternative therapies: ☐ chiropractor ☐ acupuncture ☐ physical therapy ☐ Other_____
If so any relief? _____

Relative surgical history

☐ Back surgery ☐ Neck surgery ☐ Spinal cord stimulator ☐ IT Pain pump ☐ Defibrillator/Pacemaker

☐ Other: _____

Current medications _____

_____

Blood thinners ☐Aspirin ☐Plavix ☐Warfarin ☐Lovenox ☐Pradaxa ☐Ticlid ☐Pletal

Previous pain medication

☐ Vicodin ☐ Percocet ☐ Dilaudid ☐ Oxycontin ☐ Oxycodone ☐ Fentanyl

☐ Suboxone ☐ Methadone ☐ MS Contin ☐ Other: _____

Medication allergies

☐ No known drug allergies ☐ Betadine/Iodine ☐ Contrast dye ☐ Latex ☐ Medication allergies: _____

Past medical history (please check all that apply)

☐ AIDS/HIV	☐ Diabetes	☐ Cancer: _____	☐ Hepatitis B / C	☐ Heart Disease
☐ Bleeding Disorder	☐ Stroke/Mini-Stroke	☐ Multiple Sclerosis	☐ Liver Disease	☐ Kidney Disease
☐ COPD	☐ Stomach/Intestinal Ulcers	☐ High Blood Pressure	☐ Obstructive Sleep Apnea	☐ Other: _____
☐ Alcoholism	☐ Previous Addiction	☐ Drug Abuse	☐ Bipolar Disorder	☐ Generalized Anxiety Disorder

Family history

Is your Mother living? ☐Yes ☐ No If no, age deceased_____cause of death_____

Is your Father living? ☐Yes ☐ No If no, age deceased_____cause of death_____

Family history related conditions

☐ arthritis ☐ cancer ☐ ankloysis spondylosis ☐ other_____

☐ back pain ☐ Multiple Sclerosis ☐ osteoporosis

Occupation

☐ employed ☐ currently unemployed ☐ disabled ☐ retired Position (former/current):_____

Physician Notes Only:

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NAME:_____
Last *First* *Middle initial*

Birthdate_____ **SSN** _____ **Sex:** □Male □Female

Address:_____

City: _____ **State:** _____ **Zip** _____

Home Phone (_____**)** _____ **Cell (**_____**)** _____ **Work (**_____**)** _____

Email: _____

Emergency Contact: _____ **Phone number: (**_____**)** _____

Relationship: _____

Pharmacy: _____ **Phone (**_____**)** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Marital Status: □ Single □ Married □ Widowed □ Partnered □ Divorced □Separated

Tobacco Use: □ Former □ Never □ Current _____pack(s)/day **How many years?** _____

Alcohol use: □ No □ Yes **Illicit drug use:** □ No □ Yes

Race: □ Caucasian □ African American □ Asian □ Hispanic □ Mixed race
□ Indian □ Other_____

Ethnicity: □ Hispanic □ Non-Hispanic □ Caucasian □ African American

Preferred Language: □ English □ Spanish

Is there a chance you may be pregnant: □ Yes □ No

PHYSICIAN INFORMATION

Primary Care Physician: _____ **Phone (**_____**)** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Referring Physician: _____ **Phone (**_____**)** _____

Address _____ **City** _____ **State** _____ **Zip** _____

INSURANCE INFORMATION:

Primary Insurance Carrier: _____ **Policy ID #:** _____

Secondary Insurance Carrier: _____ **Policy ID #:** _____

Tertiary Insurance Carrier: _____ **Policy ID #:** _____

Consent for Purposes of Treatment, Payment & Healthcare Operations

I consent to the use or disclosure of my protected health information by the Center for Interventional Pain Spine for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills. I understand that analysis, diagnosis or treatment of me by the Center for Interventional Pain Spine may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Center for Interventional Pain Spine is not required to agree to the restrictions that I may request. However, if Center for Interventional Pain Spine agrees to a restriction that I request, the restriction is binding. I have a right to revoke this consent, in writing at any time except to the extent that Center for Interventional Pain Spine has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, or my employer. This protected health information related to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have full access to view, and request a copy if needed, the Notice of Privacy Practices of the Center for Interventional Pain Spine. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of the Center for Interventional Pain Spine. The Notice of Privacy Practices for the Center for Interventional Pain Spine is posted in the waiting room. This Notice also describes my rights and duties of the practice with respect to my protected health information.

Center for Interventional Pain Spine reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Center for Interventional Pain Spine and requesting a revised copy be sent in the mail or asking for one at the time of my appointment.

Acknowledgement of Privacy Statement

I acknowledge receipt of the Notice of Privacy practice from Center for Interventional Pain & Spine. I understand that it is my responsibility to read the information provided therein.

Signature: _____ **Date** _____

Authorization and Assignment of Benefits

I authorize the release of any medical or other information necessary to process the insurance claim(s) for services rendered by Center for Interventional Pain & Spine LLC. I request payment of government benefits, if applicable, to the party who accepts assignment. I authorize payment of medical benefits to Center for Interventional Pain & Spine. I understand that even though I may have insurance coverage, I am ultimately responsible for payment of services rendered.

Signature: _____ **Date** _____

Appointments and Prescriptions

Should it become necessary, the following people have my permission to schedule, confirm, cancel or reschedule an appointment for me. They may also pick up prescriptions, refills, samples or anything that I have requested from the Center for Interventional Pain Spine as long as they provide valid photo ID. *NO medical information will be given.* I understand that if I need to change this information, it is my responsibility to request this in writing.

1) **Name** _____ **Relationship**: _____

   Phone No. _____

2) **Name** _____ **Relationship**: _____

   Phone No. _____

Signature _____ **Date**: _____

Release of Medical Information

Should it become necessary, the Center for Interventional Pain Spine and medical staff have my permission to discuss my health information, including test results, with the individuals listed below. The people that are listed below are also authorize for the above statement regarding appointments and prescriptions. I understand that if I need to change this information, it is my responsibility to request this in writing.

1) **Name** _____ **Relationship**: _____

   Phone No. _____

2) **Name** _____ **Relationship**: _____

   Phone No. _____

Signature _____ **Date**: _____

Financial Policy

Insurance Referrals
Our office will not see a patient without the proper referrals from your insurance company, please check with your primary care physician to make sure all referrals have been completed and also keep track of the number of visits authorized as it is the *patient's responsibility.*

Attendance Policy/No Show Fees
Three consecutive or accumulated "No Show" appointments will result in being discharged from this practice. A patient who is more than 15 minutes late for an appointment may be considered a no show. If you cancel your procedure at one of our surgery centers within less than 24-hour time frame or do not show, you will be charged a fee of $100. 00.

Self-Pay Patients/Non-Covered Services
Insurance companies do not pay for all medical services, even those that might be helpful to the patient. When a service is not covered by your insurance policy, you are responsible for the amount owed. Patients who do not have an insurance policy will be required to make a payment at the time services are rendered.

Change of Information
In order to bill your insurance carrier accurately and in a timely manner, we require you to provider our office with the following.

- Accurate Demographic Information (insurance coverage, address, phone number)
- A copy of your current insurance card (required to be presented at every visit)
- If your visit is related to an injury, you are required to provide ALL of the following information: date of injury, state of injury, injured body part, name of the insurance carrier, name and phone number of insurance adjustor, insurance policy number, and applicable attorney information.

It is the responsibility of the patient to notify us of any changes with information (insurance, phone number and/or address), and any changes in primary care physicians or other treating physicians. **If insurance claims are denied and not paid due to incorrect, outdated or insufficient information provided by the patient, the outstanding balance will become the patient's responsibility.**

Other Fees
Medical Records: Request for personal copies of medical records will take 3-5 business days to be completed. A processing fee up to $25.00 will be due at the time of request.
Medical forms will take 5-10 business days to complete; there is also a fee depending on the length and complication of the form ranging up to $25.00 and higher.
Bounced check fee is $40.00

Signature: _____ **Date** _____

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Consent for Chronic Opioid Therapy

In the chance that the Center for Interventional Pain Spine will prescribe opioid medication/narcotic analgesics to me, the decision was made because my condition is serious or other treatments have not helped my pain.

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breath rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction, and possibility that the medicine will not provide complete pain relief.

I understand that suddenly stopping some pain medicines can result in withdrawal symptoms, heart attack, stroke, seizures, permanent damage, disability or death.

I recognize my chronic pain represents a complex problem and chronic opioid therapy is only one part of my overall pain management plan. I understand my condition may also benefit from physical therapy, psychotherapy, behavioral medicine and other pain control strategies. I agree to cooperate and actively participate in all aspects of the pain management program to maximize functioning and improve coping with my condition.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug, and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

Patient Printed Name: _____ **Date**: _____

Patient Signature: _____

MEDICATION DISPENSING DISCLOSURE POLICY

Medications are dispensed through our physician dispensing licenses for your convenience. You, as the patient, reserve the right to take any prescription to any pharmacy of your choosing.
Dispensing medications in the office is provided by Center for Interventional Pain Spine for the immediate availability of the medication.

Payment of pharmaceutical benefits from commercial and Medicare payers will be assigned to Center for Interventional Pain Spine, LLC.

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CONTROLLED SUBSTANCES AGREEMENT

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you. Furthermore, this agreement is to prevent misunderstandings about certain medicines the patient will be taking for pain management.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the prescribing physician to consider the initial and/or continued use of controlled substances to treat your chronic pain:

1. **I am responsible for my controlled substance medications. If the prescription or medication is lost, misplaced, or stolen, or if I finish it before my refill date, it will not be replaced. I am responsible for taking the medication as prescribed and for keeping track of the remaining amount.**
2. I will not share, sell, trade or otherwise permit others to have access to my controlled substance medications. I will not alter/change any information on my prescriptions.
3. All controlled substances must be obtained at the same pharmacy, when possible. Should the need arise to change pharmacies; I will inform the Center for Interventional Pain & Spine. The pharmacy I have selected is _____

   Phone # _____ Location _____
4. I give the Center for Interventional Pain Spine the right to verify my prescription profile at any time by either contacting my pharmacy, other physician offices or prescription monitoring program.
5. **You must give 7 business days' notice to our office for any non-narcotic prescription refills. Prescription refills for all controlled substances can only be obtained during an office visit. There will be no exceptions made.** Refills will not be made if you "run out early", miss an appointment, nor as an "emergency" (such as on Friday afternoon because I suddenly realize I will "run out tomorrow"). Refills will not be made on nights, holidays, or weekends.
6. I agree I will not attempt to obtain any opioid medicines from another doctor or provider without informing the Center for Interventional Pain & Spine. The prescribing provider has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of accountability.
7. I understand that I may not receive medications if I miss an appointment and prescriptions will not be mailed or filled without being seen on a regular basis at the Center for Interventional Pain & Spine.
8. I understand that an unannounced pill count, urine, serum, and/or buccal toxicology screen may be requested, and my cooperation is required.
9. I understand that if I violate any of the above conditions, my controlled substance prescriptions and/or treatment with the Center for Interventional Pain Spine may be terminated immediately. If the violation involves obtaining controlled substances from another individual, I may also be reported to my physician, medical facilities and other authorities.

10. I understand that the main treatment goal is to improve my ability to function and/or work. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by following better health habits: exercise, weight control, and the non-use of tobacco and alcohol. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.
11. I will bring the containers of all medication prescribed by the Center for Interventional Pain Spine each time I have an office visit; even if there is no medication remaining. These will be the original containers from the pharmacy for each medication.
12. I will not participate in any activities that would endanger others or myself while using opioids or while experiencing side effects such as sleepiness and drowsiness. This includes driving and operating heavy machinery. I will follow the guidelines set forth by my employer regarding the use of narcotic medication.
13. I agree I will not abuse alcohol or use any illegal controlled substances, including marijuana, cocaine, heroin, etc.
14. I understand that if I am verbally or physically abusive to any staff member or engage in any other illegal activity such as altering a prescription, that the incident may be reported to other physicians, local medical facilities, pharmacies, and other authorities such as the local police, drug enforcement agency etc.
15. If it appears to the physician that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will agree to gradually taper my medication as directed by the prescribing physician
16. **I understand that if I violate ANY of the above conditions, my provider may choose to stop writing opioids for me.**

We understand that emergencies can occur and under some circumstances, exceptions to these guidelines may be made. Emergencies will be considered on an individual basis.

Patient Printed Name: _____ **Date**: _____

Patient Signature: _____

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Opioid Patient Prescriber Agreement (PPA)

This Opioid Patient/Prescriber Agreement (PPA) is designed to:

- Create an open conversation between the patient and the prescriber about the benefits, risks, and limitations of opioid medicines
- Be used as a decision-making tool before an opioid medicine is used for acute or persistent pain
- Ensure the appropriate and safe use of opioid medications

Part 1: For the Patient: Deciding whether to use opioid medications for pain. Each item will be discussed with my prescriber:

1. Pain and pain treatment are different for each person. Opioid medicines are a type of analgesic (pain reliever) medicine used to reduce moderate to severe pain. Opioid medicines can reduce some (but not all) types of pain. It is not known how much improvement in pain, activity and quality of life I may have by using these medicines. My prescriber will routinely check how I am doing to determine whether the benefits of opioid medicines outweigh the side effects of continuing to use the

2. My goal with opioid medication use are to reduce pain, making it easier to do things including but not limited to:

   - Go back to work
   - Sleep through the night
   - Climb stairs
   - Daily household chores
   - Walk short distances
   - Perform a light exercise program

3. My prescriber and I may also try alternative treatment options for my condition, including but not limited to:

   - Non-opioid medicines (for example, over-the-counter medicines such as Tylenol®, Motrin®, Aleve®), prescription medicine such as antidepressants, or anticonvulsants, as appropriate
   - Physical therapy, appropriate exercises
   - Acupuncture; Manipulation
   - Self-management techniques and coping strategies such as meditation, stress reduction, counseling and coaching, massage therapy, social support group, and attention to proper sleep
   - Surgical or other medical procedures

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4. I need to be aware of the following side effects of using opioid medications.

   - Physical dependence - If I suddenly stop taking an opioid medicine, I may experience withdrawal symptoms such as a runny nose, chills, body aches, diarrhea, sweating, nervousness, nausea, vomiting and trouble sleeping. This is called physical dependence. If this happens, it can be difficult for me to stop taking an opioid medicine, even if it's not working well. So, when I discontinue use of an opioid medicine, I understand I will need medical supervision. My prescriber will assist in me gradually lowering the dose and discontinue the opioid medication or refer me to the necessary specialist.
   - Tolerance - Over time, I may need more opioid medicine to provide similar pain relief. This is referred to as tolerance. It means that the opioid medicine may begin to feel like it's not working anymore. My prescriber can help me by making changes to the opioid medicine or refer me to the necessary specialist.
   - Addiction - I may develop an intense craving for opioid medicine, even if I take it as prescribed. When a person is not able to control their opioid medicine use and continues using the medicine despite the side effects, this is called addiction. If addiction occurs, it can be difficult to stop taking the opioid medicine, and I will need medical supervision. My prescriber can assist me in gradually lowering the dose in order to discontinue the opioid medicine or refer me to the necessary specialist.

5. Table 1 - Opioid Side Effects: The table below lists common and potential opioid side effects in alphabetical order and the percentage of patients that experience them.

Opioid Side Effects	**Percentage of Patients**
addiction	5 - 30%
breathing problems during sleep, disruption of sleep	25%
confusion	*
constipation	30 - 40%
depression	30 - 40%
drowsiness	15%
dry mouth that can cause tooth decay	25%
intestinal blockage	<1% per year
itching	*
lowered testosterone levels, infertility and impotence	25% - 75%
nausea or vomiting	*
overdose – can lead to death	< 1% per year
physical dependence	*
tolerance	*
unexpected increased pain	*

**Percentage of patients experiencing side effect unknown*

6. Opioid medicine can impair my judgment and responses. I understand that I must be cautious if I drive or operate machinery or do any activity that requires me to be alert until I am sure I can perform such activities safely.

7. Taking even small amounts of alcohol or taking medicines such as sleeping pills, antihistamines, and anti-anxiety medicines while taking an opioid medicine will increase the chance of opioid medicine side effects. These side effects can include drowsiness, dangerously slowed breathing, and decreased alertness.

8. It may be necessary that I routinely provide a urine, saliva, or blood sample before or while I am taking opioid medicine.

9. I agree to abide by the random pill count policy which requires I bring all of my medication into the office within the allotted time frame provided to me by the office.

10. I agree to discuss with my prescriber my and my family's past and present use of any habit-forming substances before we decide to try to treat my condition with an opioid medicine. These habit-forming substances can include tobacco and alcohol, as well as other opioid medicines or street drugs.

11. My prescriber and I have discussed all the information above and have made a decision about using opioid medicines.

Part 2: For the Patient: My obligation to using opioid medicines safely

Now that my prescriber and I have agreed that I will try an opioid medicine, I understand that I need to take an active role in my own health care to get the most benefit and reduce the chance of side effects from using an opioid medicine. My prescriber wants me to have the following information so that I may have the best possible pain reduction while also protecting my health and reducing the chances of possible harm to myself and others while I am taking an opioid medicine.

12. I told my prescriber about all the medicines I am taking, including any prescription, over the counter and herbal medicines. I will also discuss with my prescriber any new medicine that I take in the future. Some medicines and other substances such as alcohol, sleeping medicines, antihistamines and anti-anxiety medicines can increase the chance of opioid medicine side effects. If I use these medicines along with an opioid medicine, they can slow my breathing. This can lead to serious problems, including an increased chance of stopping breathing and death.

13. If I start to have more pain or other unusual or severe side effects, I will contact my prescriber right away. We may need to change the dose or try a different opioid medicine. I will not make any changes to the opioid medicine without first talking to my prescriber.

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14. I will tell my prescriber if I am pregnant or planning to become pregnant. Taking opioid medicine during pregnancy can harm my unborn baby.

15. I will not share this opioid medicine with other people. My prescriber and I have selected this opioid medicine for me, and it is only for me. It is against the law to share an opioid medicine with other people. Sharing an opioid medicine with another person can cause serious harm to them, including death.

16. I will keep my opioid medicine in a secure place where other people cannot reach it. If someone accidently takes some of my opioid medicine or I accidentally take too many doses, I will contact my prescriber or call the Poison Control Center at 1-800-222-1222.

17. I will remove expired, unwanted, or unused opioid medicine from my home to avoid accidentally harming children, other adults, or myself, and correctly dispose of them.

    - I may be able to drop off unused opioid medicine through a "medicine take-back program". A "medicine take-back program" is an official place and time for dropping off unused opioid and other medicines.
    - If I cannot find a "medicine take-back program" or if I want to remove the medicine from my home right away, I can flush my opioid medicine down the toilet.
    - My opioid medicine can also be mixed with cat litter or coffee grounds and thrown out with the household trash.
    - I can get more information about disposing of my opioid medicine by calling 1-888-FDA-INFO (1-888-463-6332) or at the following website https://www.fda.gov/drugs/safe-disposal-medicines/disposal-unused-medicines-what-you-should-know

Part 3: For the patient and the prescriber.

- My prescriber and I have discussed all the items on this checklist.
- We both agree that an opioid pain medicine is the best choice for my condition at this time.
- My prescriber and I agree that we will go over this checklist again in the future.

Patient Printed Name: _____ **Date**: _____

Patient Signature: _____

NOTICE OF PRIVACY PRACTICES
Center for Interventional Pain & Spine

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

If you have any questions regarding this notice, you may contact our Privacy Officer at:

Address: Center for Interventional Pain & Spine
Attention: Jen Colonna ,Privacy Officer
291 Carter Dr. Suite B
MIddletown, DE 19709
Telephone: 1-844-365-7246
Fax: 1-844-516-0080

I. YOUR PROTECTED HEALTH INFORMATION

We are required by the federal privacy rule to maintain the privacy of your health information that is protected by the rule, and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We are required to abide by the terms of the notice currently in effect. We are also required to notify you following a breach of your unsecured protected health information.

Generally speaking, your protected health information is any information that relates to your past, present or future physical or mental health or condition, the provision of health care to you, or payment for health care provided to you, and individually identifies you or reasonably can be used to identify you. Protected health includes genetic information. Protected health information typically excludes health information of persons who have been deceased for more than fifty (50) years.

Your medical and billing records at our entity are examples of information that usually will be regarded as your protected health information.

II. USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

A. Treatment, payment, and health care operations

This section describes how we may use and disclose your protected health information for treatment, payment, and health care operations purposes. The descriptions include examples. Not every possible use or disclosure for treatment, payment, and health care operations purposes will be listed.

1. Treatment

We may use and disclose your protected health information for our treatment purposes as well as the treatment purposes of other health care providers. Treatment includes the provision, coordination, or management of health care services to you by one or more health care providers. Some examples of treatment uses and disclosures include:

- We may disclose medical information about you to doctors, nurses, technicians, medical students and other trainees, or other personnel who are involved in your care at our office.
- We may share medical information about you in order to coordinate the different services you need, such as prescriptions, lab work and x-rays.
- We may disclose medical information about you to people outside our office who may be involved in your medical care, such as other physicians, family members, or other health care related entities such as skilled nursing care facilities with whom you seek treatment.

2. **Payment**

We may use and disclose your protected health information for our payment purposes as well as the payment purposes of other health care providers and health plans so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. Some examples of payment uses and disclosures include:

- Sharing information with your health insurer to determine whether you are eligible for coverage or whether proposed treatment is a covered service.
- We may need to give your health insurance company information about a procedure you received so your health insurance company will pay us or reimburse you for the procedure. This may include submission of a claim form.
- Providing supplemental information to your health insurer so that your health insurer can obtain reimbursement from another health plan under a coordination of benefits clause in your subscriber agreement.
- We may also disclose your medical information to other healthcare providers so that they can bill for health care services that they provided to you, such as ambulance services.
- Mailing statements to you for our services in envelopes with our Center for Interventional Pain & Spine and return address.
- Provision of a bill to a family member or other person designated as responsible for payment for services rendered to you.
- Providing information to a collection agency or an attorney for purposes of securing payment of a delinquent account.
- The sale of protected health information and the use of such information for paid marketing require authorization from the individual;
- Other uses and disclosures not described in the NPP will be made only with authorization;
- Individuals can restrict disclosures to their health plans for services for which they pay " out of pocket" and in full.

3. **Health care operations**

We may use and disclose your protected health information for our health care operation purposes as well as certain health care operation purposes of other health care providers and health plans. Some examples of health care operation purposes include:

- We may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you.
- We may use and disclose medical information about you for various quality assurance and quality improvement activities.
- Population based activities relating to improving health or reducing health care costs.
- Conducting training programs for doctors, nurses, technicians, medical and nursing students, and other personnel.
- Accreditation, certification, licensing, and credentialing activities.
- Health care fraud and abuse detection and compliance programs.
- Conducting other medical review, legal services, and auditing functions.
- Business planning and development activities, such as conducting cost management and planning related analyses.
- Sharing information regarding patients with entities that are interested in purchasing our entity and turning over patient records to entities that have purchased our entity.
- Other business management and general administrative activities, such as compliance with the federal privacy rule and resolution of patient grievances.

B. Other uses and disclosures not requiring authorization

We may use and disclose your protected health information for other purposes.

- Family members or close friends involved in your care or payment for your treatment.
- In a disaster relief effort so that your family can be notified about your condition and location.
- A government disaster relief agency if you are involved in a disaster relief effort.

- To inform you of treatment alternatives or benefits or services related to your health. If we receive anything of value for making these communications, we will notify you of this fact, and you will have an opportunity to opt out of future communications.
- To contact you to raise funds for our entity. Information used and disclosed for fundraising will be limited to your name and other limited information permitted by law. You will have the opportunity to opt out of receiving future fundraising communications. *[remove if not applicable]*
- As required by law.
- Public health activities, including disease prevention, injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect or domestic violence (if you agree or as required by law).
- Health oversight activities (e.g., audits, inspections, investigations, and licensure activities).
- Lawsuits and disputes (e.g., as required by a court or administrative order or in response to a subpoena or other legal process).
- Law enforcement (e.g., in response to legal process or as required or allowed by law).
- Coroners, medical examiners, and funeral directors.
- Organ and tissue donation organizations.
- Certain research projects as approved by an Institutional Review Board or if certain conditions are met.
- To prevent a serious threat to public health or safety.
- To military authorities if you are a member of the armed forces.
- National security and intelligence activities.
- Protection of the President or other authorized persons or foreign heads of state, or to conduct special investigations.
- Inmates or others in custody to a correctional institution or law enforcement.
- Workers' Compensation (in compliance with applicable laws).
- To business associates (individuals or entities that perform functions on our behalf) (e.g., to install a new computer system) provided they agree to safeguard the information.
- We may incidentally disclose protected health information as by-product of an otherwise permitted use or disclosure. For example, other patients may overhear your name being paged in the waiting room.
- We may disclose proof of immunization to a school for admission with oral or written agreement from a parent/guardian or other person acting in *loco parentis*, or directly from the individual if an adult or emancipated minor.

C. Uses and disclosures requiring authorization

All other purposes that do not fall under a category listed above, will require your written authorization to use, disclose or sell your protected health information. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization. You may revoke your authorization, and thereby stop any future uses and disclosures, by notifying us in writing.

III. PATIENT PRIVACY RIGHTS

You have the following rights regarding your medical records. Please contact our Privacy Officer to exercise your rights.

A. Right to request restriction

You may request limitations on how we use or disclose your medical information for health care treatment, payment, or operations (e.g., you may ask us not to disclose that you have had a particular surgery). We are not required to agree to your request, except for requests to restrict disclosures to a health plan for purposes of payment or health care operations when you have paid in full out-of-pocket for the item or service covered by the request and when the disclosure is not required by law. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

B. Right to confidential communications

You may request communications in a certain way or at a certain location. For example, you might request that we only contact you by mail or at work. We will accommodate reasonable requests for confidential communications but you must specify how or where you wish to be contacted and how payment will be handled.

C. Right to accounting of disclosures

You may request a list of instances where we have disclosed your medical information for certain types of disclosures. The accounting will not include disclosures that we are not required to record, such as disclosures made pursuant to an authorization. This right is limited to disclosures within six years of the request The first accounting you request within a 12-month period is free, but we will charge a fee for any additional lists requested within the same 12-month period.

D. Right to inspect and copy

You have the right to look at and obtain a copy of your medical records, billing records, and other records used to make decisions about your care. We may charge you a fee for our postage and labor costs and supplies to create the copy. Under limited circumstances, your request may be denied and you may request review of the denial by another licensed health care professional of our choosing. We will comply with the outcome of the review. If your information is stored electronically and you request an electronic copy, we will provide it to you in a readable electronic form and format.

E. Right to request amendment

If you believe that the medical information we have about you is incorrect or incomplete, you have the right to request that your records be amended. Under limited circumstances, we may deny your request for amendment. If denied, you will receive an explanation for the decision and information explaining your options.

F. Right to copy of privacy notice

You may request a paper copy of this Notice at any time by contacting our Privacy Officer. You may also obtain an electronic copy of this Notice on our website. The Notice will be provided to you in other formats if you require special accommodations by contacting our privacy officer.

G. Right to notification of breach

We are required by law to notify affected individuals following a breach of unsecured medical information. A breach is generally defined as any disclosure of unsecured protected health information not permitted by this notice. Examples of exceptions include unintentional access by employees and inadvertent disclosures within an office.

IV. CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We further reserve the right to make any new provisions effective for all protected health information that we maintain at the time of the change, including information that we created or received prior to the effective date of the change.

We will post a copy of our current notice in our waiting room and also on our website. At any time, patients may review the current notice or request a paper copy by contacting our privacy officer.

V. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the Secretary of the United States Department of Health and Human Services. *You will not be penalized or retaliated against in any way for filing a complaint.*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

Notice of Privacy Practices. CENTER FOR INTERVENTIONAL PAIN & SPINE has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information, how you can access your protected health information, and other rights concerning your protected health information.

I acknowledge that I received or was offered a copy of CENTER FOR INTERVENTIONAL PAIN & SPINE Notice of Privacy Practices.

_____

Print name of patient

_____ _____

Signature of patient/personal representative/surrogate Date

_____ _____

Name of personal representative/surrogate Relationship to patient

GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

(For office use only when efforts to obtain acknowledgment of receipt of notice are unsuccessful)

- ❑ Individual refused copy of NPP
- ❑ Individual accepted copy of NPP; refused to sign Acknowledgement of Receipt
- ❑ Communication barriers prohibited obtaining acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other _____

_____ _____

Signature of staff member Date

_____

Print name of staff member

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

Read entire document before signing: This authorization gives permission to use or disclose health information related to the patient listed below.

Patient Name: _____

Account Number: _____ Date of Birth: ____/____/_____

1. Center for Interventional Pain & Spine is authorized to disclose the health information of the above named individual as described in this authorization:
2. The Center for Interventional Pain & Spine may discuss and/or release protected health information with the following individuals (User/Recipient):
   Name _____Phone:_____
   Name _____Phone:_____
   May we leave telephone messages at the telephone number provided? ____yes ____no
3. The following health information can be discussed and/or released by this authorization to the individuals listed above:
   ☐Complete medical record
   ☐Appointment information including reason for appointment and times
   ☐Results of diagnostic testing and other information related to your health
   ☐Exceptions (Please List): _____

   Psychotherapy notes will not be covered unless specifically covered in a separate authorization. Please note that other mental health and behavioral information included in any checked category will be covered by this authorization unless excluded below.

4. The following information is specially protected by state and/or federal law. Please indicate below whether you would like the following information to be released

				Initials
Substance abuse records(drug or alcohol)	Yes ☐	No ☐	NA☐	_____
Mental health records protected by the Mental Health Procedures Act	Yes ☐	No ☐	NA☐	_____
HIV/AIDS related information	Yes ☐	No ☐	NA☐	_____

5. Please specify any other restrictions on the covered information: _____

I am requesting use or disclosure of the covered health information for the following purpose:

☐My personal use ☐Further medical treatment
☐ Insurance eligibility or benefits ☐School
☐Legal investigation or action ☐Other (please describe) _____

7. I understand that I have the following rights:

- **Right not to sign.** You may refuse to sign this authorization. Refusal to sign will not affect your ability to obtain treatment by the Center for Interventional Pain & Spine except when health services are solely for the purpose of reporting to a third party. An example is a pre-employment physical.
- **Right to revoke.** You may revoke this authorization at any time. Your revocation will not apply to any actions that we have already taken in reliance on this authorization. To revoke this authorization, you must submit a written revocation to our privacy officer at the following address:
  Center for Interventional Pain & Spine
  Attention: Jennifer Colonna SA-C, CHCO /Privacy/Security Officer
  291 Carter Dr. , Suite B Middletown, DE 19709
- **Re-disclosure.** I understand that once the covered health information has been disclosed, it may be no longer protected by privacy laws and may be re-disclosed by the recipient.

8. **Expiration.** This authorization expires as of the following date or event_____

I have read and understand this authorization, and authorize the use or disclosure of the covered health information as described in this authorization.

_____ _____
Signature of patient (or personal representative/surrogate) Date

Personal Representative/Surrogate Information (as applicable):

_____ ____ _____
Name of personal representative Relationship to patient