

PAIN & ARTHRITIS CENTER, P.C.

Patient Name: _____ Date of Birth: _____
Last MI First

Today's Date: _____

New Patient Evaluation for Narcotic Detoxification

1. What are you here for? _____
2. Do you have chronic pain? No Yes If no, skip to question 12.
3. If yes, where is the pain? _____
4. How long have you had the pain? _____
5. What is the cause of the pain? _____
6. How was the pain treated in the past? Physical Therapy Chiropractic Acupuncture NSAIDS
 Muscle Relaxant Narcotic Drugs Other _____
7. What treatment helped pain in the past? _____
8. Have you had surgery(s) for the pain? No Yes
If yes, when was the surgery(s)? _____
9. What kind of surgery(s)? _____
10. What doctor did the surgery(s)? _____
11. What pain management doctor(s) have you seen? _____
12. Which doctor(s) prescribed narcotic medication(s) to you previously? _____
13. Which narcotic medication(s) were prescribed to you previously? _____
14. Are you currently taking narcotics? No Yes If yes, please list _____
15. Have you ever injected illicit drugs to yourself or has someone else injected you? No Yes
If yes, when was the last time? _____ If yes, what drug(s)? _____
16. Are you currently using illicit drugs? No Yes
17. When did you begin narcotic detox? _____
18. Which doctor prescribed narcotic detox drugs for you? _____
19. Do you want to be detoxed now? No Yes
20. What medical conditions do you have? _____
21. List all medications you are currently taking _____
22. Family addiction history. **List addiction (alcohol, illicit or narcotic) and indicate the family member(s) child(ren), sibling(s), parent(s), and/or grandparent(s):**

Addiction

Family Member

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever used narcotic pain medications? No Yes

What medications worked for your chronic pain? _____

Which doctor currently prescribes your pain medications? _____
First Last

Medication Allergies? No Yes _____

Family History: List Major Illness Your Family Member Had _____

Social History: Your Occupation _____

Do you use tobacco? No Yes If yes, how may packs per day? _____

Do you have a history of heavy alcohol use? No Yes

Are you currently drinking alcohol? No Yes If yes, how frequent and how much? _____

Have you ever used illicit drugs? No Yes _____

Do you have a history of Narcotic addiction? No Yes

Have you ever had Narcotic detox? No Yes If yes, when was the most recent time?

PAST MEDICAL HISTORY

General: Insomnia Sleep Apnea Other, please explain _____

Mental Health: Depression Suicidal Anxiety Panic Attack Bipolar Psychosis
 Schizophrenia Other _____

Musculoskeletal: Osteoarthritis, in which joint(s) _____
 Cervical Spine Disc Disease Cervical Spine Arthrosis Cervical Spine Root Nerve Impingement
 Thoracic Spine Disc Disease Thoracic Spine Arthrosis Thoracic Spine Nerve Root Impingement
 Lumbar Disc Disease Lumbar Spine Arthrosis Lumbar Spine Nerve Root Impingement
 "Sciatica" Other _____

Rheumatology: Fibromyalgia Lupus Scleroderma Sjogren's Syndrome Gout Osteoarthritis
 Marfan's Syndrome Psoriatic Arthritis Rheumatoid Arthritis Ankylosing Spondylitis
 Other, please explain _____

Neurology: Migraine Non-Migraine Headache Cluster Headache Peripheral Neuropathy TIA
 Brain Tumor Brain Aneurysm Carotid Artery Artherosclerosis Seizure Disorder Stroke
 Multiple Sclerosis Head Trauma Other _____

Cardiology: CHF Pericarditis Hypertension Coronary Artery Disease
 Hyperlipidemia Angina Chest Pain Cardiac Arrhythmia Heart Valve Defect
 Blood Clots in Legs or Arms Pace Maker Placement Coronary Angiogram Coronary PTCA
 Other _____

Pulmonology: Asthma COPD Pneumonia Pulmonary Hypertension
 Pulmonary Embolism Idiopathic Pulmonary Fibrosis Pleuritis
 Other _____

Gastroenterology: IBS Gastric Ulcer GERD Hiatal Hernia Crohn's Disease Ulcerative Colitis
 Hepatitis A Hepatitis B Hepatitis C Other

Hematology: Anemia Leukopenia Thrombocytopenia Coagulopathy

Endocrinology: Osteoporosis Diabetes Hypogonadism (low male hormone)
 Adrenal Gland Disease Hypothyroidism Parathyroid Disease Paget's Bone Disease
 Other _____

Nephrology: Kidney Stones Abnormal Kidney Function Frequent Urinary Tract Infection
 Bladder Problems (please specify) _____

Skin: Photo Sensitivity Psoriasis Rosacea Other _____

Infectious Disease: Lyme Disease HIV Tuberculosis Hepatitis B Hepatitis C
 Other _____

PAST SURGICAL HISTORY

List all surgeries you have had in your life

Name of Surgery

Date

Surgeon's Name

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT MEDICATIONS

Name of Medication

Dose

Time of Day

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAIN & ARTHRITIS CENTER, P.C.

Date: _____ Do you have Medicare? Yes or No Are you Disabled? Yes or No Male or Female

Patient Name: _____

Last

MI

First

Physical Address: _____

Mailing Address if different than above: _____

Home Phone: _____ Cell Phone: _____ Work Number: _____

Primary Care Doctor: _____ Primary Doctor Office Number: _____

Referring Doctor: _____ Referring Doctor Office Number: _____

Patient Date of Birth: _____ Social Security Number: _____

Marital Status: Married Single Separated Widowed Partner

Spouse's Name: _____

Emergency Contact & Relationship: _____

Emergency Contact Phone Number(s): _____

Primary Insurance Coverage: _____

ID Number: _____ Group Number: _____

Employer: _____ Phone Number: _____

Policy Holder: _____ Date of Birth: _____

Relationship to Patient: _____ Social Security Number: _____

Policy Holder Address: _____ Phone Number: _____

Secondary Coverage: _____

ID Number: _____ Group Number: _____

Employer: _____ Phone Number: _____

Policy Holder: _____ Date of Birth: _____

Relationship to Patient: _____ Social Security Number: _____

Policy Holder Address: _____ Phone Number: _____

By signing this form you are stating the above information is true and accurate to be best of your knowledge, failure to provide all accurate insurance information could result in a denial of claims being paid by your insurance company and could result in the charges being billed to you the patient/guarantor for payment.

Print your name

Sign your name

____/____/____
Date

Pain & Arthritis Center, P.C.

6120 Brandon Avenue, Suite 201
Springfield, VA 22150

2124 Richmond Highway, Suite 101
Stafford, VA 22554

Telephone: 703-923-9536

Fax: 703-923-9537 540-318-6259

Financial Policy

1. Pain and Arthritis Center participates with most insurance carriers. As a courtesy we will contact your insurance carrier to confirm coverage and file your claims for you.
2. Co-pays and deductibles are due at the time of service.
3. You are responsible for the percentage of the service cost that is not covered by your insurance, (i.e. Co-pays, deductibles and co-insurance).
4. Please be advised that if for any reason your insurance carrier fails to cover cost for services rendered, you will become the responsible party.
5. Should your account need to be referred to an outside collection agency, you will be responsible for a **33 percent collection fee**, which will be added to the outstanding balance.

General Policy

1. Primary Care Referrals – Please obtain appropriate referrals in advance of your visits. Unfortunately, patients cannot be seen without the appropriate referrals. Should, for some reason you are seen without a valid referral, you are accepting responsibility of the balance unless you obtain a valid referral on that day for the visit.
2. Should you need a copy of your medical record to give to another doctor you must have the office submit a request for records stating what they need from our office, because of the nature of our practice, patients will **NOT** be given a copy of their medical records.
3. Tardiness – Please call if you are running late. You may be asked to reschedule your appointment if you arrive 15 minutes late or more.
4. Cancellations – We ask that patients contact our office at least 24 business hours prior to their appointment time, if they need to cancel or reschedule. A fee of \$50 will be assessed when the appropriate cancellation time is not given and payment is due before your next appointment.
5. Get your prescriptions and refills for all your medications at the time of your visit! If you do not, you may need to return for an appointment or your insurance **will be** billed a low level visit!

I have read this policy and I agree to the terms and conditions of the policy.

Print your name

Sign your name

____/____/____
Date

Witness name

Witness Signature

____/____/____
Date

Pain & Arthritis Center, P.C.

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Pain & Arthritis Center's health care operations. The Notice of Privacy Practices also describes my rights and Pain & Arthritis Center's duties with respect to my protected health information. The Notice of Privacy Practices is available at our office and on our website at www.painandarthritiscenter.com.

Pain & Arthritis Center 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 and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing Pain & Arthritis Center's website.

Signature of Patient or Representative

Name of Patient or Representative & Relationship

____/____/_____
Date

I further (circle one) authorize/ revoke authorization to have access to my records pertaining to billing and treatment to the following:

Name and relationship to patient: _____

Name and relationship to patient: _____

Name and relationship to patient: _____

Name and relationship to patient: _____

Office Witness

____/____/_____
Date

Pain & Arthritis Center, P.C.

6120 Brandon Avenue, Suite 201, Springfield, VA 22150

2124 Richmond Highway, Suite 101, Stafford, VA 22554

Phone: 703-923-9536 Fax: 703-923-9537 540-318-6259

NOTICE OF PRIVACY PRACTICES

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

OUR COMMITMENT TO YOUR PRIVACY: Our practice is dedicated to maintaining the privacy of your Individually Identifiable Health Information (IIHI). This notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. At **Pain & Arthritis Center, PC** the privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail and asking for one at the time of your next appointment.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION: Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where, and why others may access your health information
- make more informed decisions when authorizing disclosure to others

YOUR HEALTH INFORMATION RIGHTS: Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights:

RIGHT TO RECEIVE CERTAIN ACCOUNTING DISCLOSURES: This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. This request must be made in writing to our office and we will review your request and respond within 30 days.

RIGHT TO OBTAIN A PAPER COPY: You are entitled to receive a paper copy of our notice of privacy practices. To obtain a paper copy of this notice, please contact the Office to have one mailed to you, ask for a copy at your next appointment or visit our web site at www.painandarthritiscenter.com.

OUR RESPONSIBILITIES: Pain & Arthritis Center, PC is required to:

- notify you if we are unable to agree to a requested restriction
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

- maintain the privacy of your health information
- abide by the terms of this notice

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us. We will not use or disclose your health information without your authorization, except as described in this notice.

COMPLAINTS: If you have questions and would like additional information, you may contact our office at 703-923-9536. If you believe your privacy rights have been violated, you can file a complaint with our office in writing. There will be no retaliation for filing a complaint.

HOW WE MAY USE AND DISCLOSE YOUR INFORMATION

TREATMENT: For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this practice.

PAYMENT: For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

HEALTHCARE OPERATIONS: For example: Members of this office may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

BUSINESS ASSOCIATES: There are some services provided in our organization through contacts with business associates. Examples include: physician services in the emergency department, radiology, and certain laboratory tests. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

APPOINTMENT REMINDERS: *We may contact you by phone or leave a message on your home, work or cell phone or with family members as a reminder that you have an appointment scheduled for medical care at the office. Please notify us if you do not wish to be contacted for appointment reminders.*

NOTIFICATION: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

COMMUNICATION WITH FAMILY MEMBERS: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

DISCLOSURES REQUIRED BY LAW: We may use or disclose your protected health information to the extent that the use or disclosure is required by federal, state or local law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

WORKERS' COMPENSATION/HEALTH OVERSIGHT ACTIVITIES: Your Protected Health Information may be disclosed by us as authorized to comply with Workers' Compensation laws and other similar legally-established programs. We may disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

LAWSUITS AND DISPUTES: If you are involved in a lawsuit or a dispute, we may disclose your medical information in response to a court or administrative order. We may also disclose your medical information in response to a subpoena.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION: We will use or disclose your Protected Health Information for any purpose other than those identified in the previous sections without your specific, written **Authorization**. If you give us **Authorization** to use or disclose health information about you, you may revoke that **Authorization** in writing at any time. If you revoke the **Authorization**, we will no longer use or disclose information about you for the reasons covered by your written **Authorization**, but we cannot take back any uses or disclosures already made with your permission.

FOOD AND DRUG ADMINISTRATION (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Pain & Arthritis Center, P.C.

CONTRACT FOR NARCOTIC MEDICATION USAGE

1. I have agreed to use opioid medications as part of my pain management for a limited period.
2. I understand that the use of opioid medications has the risk for misuse, abuse, and addiction.
3. **I will not use any illegal substances, such as heroin, marijuana, cocaine, etc.**
4. I agree that the opioid medications are **strictly for my own use**. I will not share, sell or trade my opioid medications with others.
5. I certify that I will receive opioid medications and all other controlled substance medications **only from the physician at Pain & Arthritis Center**.
6. It is my responsibility to notify my physician if any side effects of the medications continue.
7. I agree to have my opioid medications filled **at a single pharmacy**.
8. I understand that **physical dependency** toward opioid medications is expected after long term use.
9. I agree to adhere strictly to medical instructions and laws governing the use of these medications and I will **not use illegal or alcohol** while I am on these medications.
10. I understand that I may be required to come to the clinic **weekly, every 2 weeks, every 3 weeks or monthly** at the start of my treatment or anytime during my treatment.
11. I agree to submit **urine and blood samples** for both prescribed and non-prescribed substances upon the request of the prescribing physician.
12. I agree to bring remaining prescribed opioid tablets to my physician for **“pill count” if requested** by the physician.
13. I agree that I will **not take more medication than prescribed** and will **not request early refills**.
14. **Lost, misplaced or stolen medications WILL NOT BE REPLACED.**
15. I understand that my physician has to make periodic assessment of my response to medications; I will therefore follow my physician’s instruction and **return to the clinic every month**. Failure to follow up with my physician may result in discontinuation of opioid medication treatment and patient-physician relationship.
16. **Refill policy:** I understand that refills of narcotic medications will be made only during a regular office visit. **Refills will not be called in or mailed.** I agree to call my physician’s office at least **3 business days in advance to request a refill** for non-narcotic prescriptions.
17. If it appears to the physician that there is no improvement to my daily function or quality of life from my opioid medications, the medications may be discontinued.
18. **Narcotic medication addiction is recognized when the patient abuses the drug to obtain mental numbness or euphoria, when the patient shows drug craving behavior or “doctor shopping”, a manipulative attitude toward the physician in order to obtain the drug, or when the drug is quickly escalated without correlation to pain relief. If the patient exhibits such behavior, the drug will be discontinued, and the patient may be discharged.**

19. I understand that opioid medications may cause a **variety of side effects**, including, but not limited to nausea, vomiting, drowsiness, constipation, fluid retention and mental slowing, flushing, sweating, itching, weight changes, suppression of male hormone, suppression of thyroid function, suppression of menstrual cycle, suppression of immune system, jerkiness, and urinary difficulty.
20. I understand that these are potentially dangerous medications and that, if taken improperly, may lead to excess sedation, respiratory depression, and death.
21. I **authorize the release** of my information and records to my pain physician from my other health care providers, pharmacies, insurance companies, my family or employer.

FEMALE PATIENTS: You may not enter or continue the treatment program while pregnant!

1. **It is my responsibility to IMMEDIATELY notify the Pain & Arthritis Center that I am pregnant or if I become pregnant during my treatment.**
2. **I understand that my treatment will stop until after I have given birth or I am no longer pregnant. I MUST IMMEDIATELY find another detox doctor/clinic and OB/GYN to treat myself and the baby during my pregnancy.**
3. **I WILL BE RELEASED** from the clinic if I neglect to inform them of my pregnancy.
4. The Pain & Arthritis Center **is not liable** for any effects or death of a fetus/baby from improper or continued use of medications during pregnancy.

I certify that I have read and understand the above information and I hereby give my consent to participate in opioid medication therapy.

Patient Name: _____

Patient Signature: _____ **Date Signed:** _____

Pharmacy Name & Phone Number: _____

Physician Signature: _____, Cindy Y. Zhang, M.D.