Patient Packet

PLEASE READ THE ATTACHED DOCUMENTS IN THEIR ENTIRETY. YOU ARE RESPONSIBLE FOR WHAT YOU SIGN.

185 Chateau Drive, Suite 302
Huntsville, AL 35801
Phone: (256) 885-1605
Fax: (256) 885-1905

Today's Date:_____

Patient Information and Profile. *Please complete or indicate the following information.*

Last Name:_____ First Name:_____ Middle/ Initial:_____
Preferred Name:_____ Maiden Name:_____ Prefix/Suffix:_____
Date of Birth:_____ Male / Female SSN:_____

Race:
_____American Indian/ Alaska Native
_____Asian
_____Black/ African American
_____Native Hawaiian/ Pacific Islander
_____White
_____Other

Ethnicity:
_____Hispanic or Latino
_____Not Hispanic or Latino
_____Declined

Drivers' License Number:_____

Place of Employment: _____

Native Language:_____Marital Status: Married:_____ Single:____ Divorced:__ Widowed:_

Patient Address:_____

Zip Code:_____ City:_____ State:_____ County:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Which is your preferred number for contact:_____Email:_____You agree, in order for us to service your account, remind you of your visit or to collect monies you may owe, HUNSTVILLE PAIN MANAGEMENT, and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that HUNTSVILLE PAIN MANAGEMENT, its employees and/or agents may contact me/us as described above.

Signature: _____ **Date:** _____

Pharmacy Name:_____ Phone Number:_____
Pharmacy Fax:_____ City:_____ State:_____

** Emergency Contact: **Person(s) must be added on HIPAA form (page 16)** **

Name: _____ Relation:_____ Phone Number:_____

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Associated Party. *If you are not the primary insurance holder on your plan, or if you have a family member who is also a patient, please fill out the following information.*

Policy Holder's Name:_____ Date of Birth:_____
Is this person financially responsible for your visit? Y / N Their relationship to you:_____

Associated Party's Name:_____ Date of Birth:_____ Is this person financially responsible for your visit? Y / N Their relationship to you:_____

Insurance. *Please fill out or indicate the following insurance information.*

Insurance Name: _____ Policy Holder: _____

Policy Holder Date of Birth: _____ Policy Number: _____

Group Number: _____ Effective Date: _____ Expiration Date: _____

Secondary Insurance Name: _____Policy Holder: _____

Policy Holder Date of Birth: _____ Policy Number: _____

Group Number: _____ Effective Date: _____ Expiration Date: _____

Tertiary Insurance Name: _____Policy Holder: _____

Policy Holder Date of Birth: _____ Policy Number: _____

Group Number: _____ Effective Date: _____ Expiration Date: _____

ADDING COLLECTION FEES TO ACCOUNT BALANCES

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.3%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.

Patient/Guarantor Signature _____ Date _____

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Please complete ALL sections of this multi-paged form. This will help Dr. Thacker get to know your current condition and your medical history. We rely on accurate and complete information in order to provide you with the best care possible. Please take your time and feel free to ask our front desk or call (256) 885-1605 if you have any questions or are unsure how to complete any section of this form.

Your Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Family Physician: _____

Height: _____ Weight: _____

Chief Complaint: _____

REFERRAL

Referring Physician _____

PREFERRED PHARMACY

Pharmacy Name:_____ Phone Number: _____

Street Address: _____ City/State/Zip: _____

PAIN DESCRIPTION

Use the pain scale described below to rate your pain for the question below:

0 – Pain Free
1 – Very minor annoyance, occasional minor twinges
2 – Minor annoyance, occasional strong twinges
3 – Annoying enough to be distracting
4 – Can be ignored if you are really involved in your work/task, but still distracting
5 – Cannot be ignored for more than 30 minutes
6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
9 – Unable to speak, crying out or moaning uncontrollably, near delirium
10 – Unconscious, pain makes you pass out

____ What number on the pain scale (0-10) best describes your pain **right now**?

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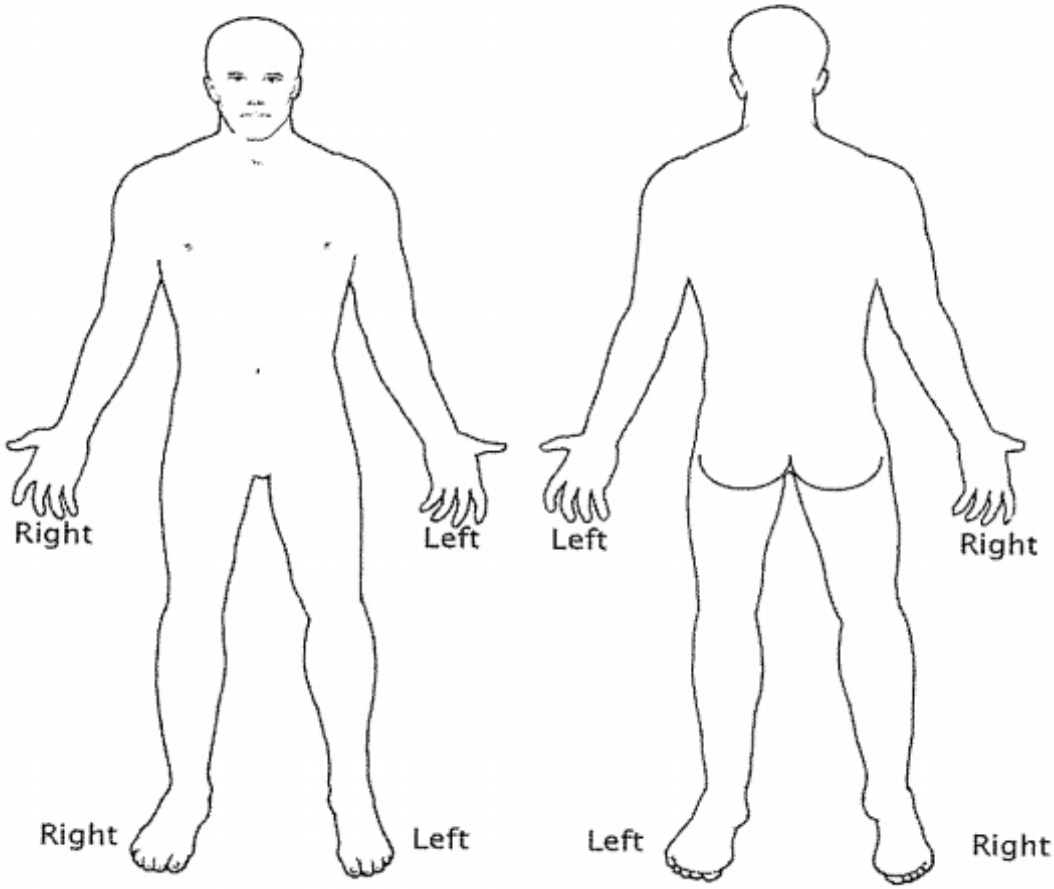
Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

"N" = Numbness
"S" = Stabbing
"B" = Burning
"P" = Pins and Needles
"A" = Aching



Where is your worst area of pain located? _____
Does this pain radiate? If so, where? _____
Please list any additional areas of pain? _____

ONSET OF SYMPTOMS

Approximately when did this pain begin? _____
What caused your current pain episode? _____
Is your pain the result of a Motor Vehicle Accident, Work Injury, or Personal Injury (legal term describing injury sustained to yourself because of the negligence of another)? ☐ Yes ☐ NO
How did your current pain episode begin? ☐Gradually ☐ Suddenly
Since your pain began, how has it changed? ☐Decreased ☐Increased ☐Stayed the same

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PAIN DESCRIPTION

Check all of the following that describes your pain:

☐Aching ☐Hot/Burning ☐Shooting ☐Stabbing/Sharp
☐Cramping ☐Numbness ☐Spasming ☐Throbbing
☐Dull ☐Shock-like ☐Squeezing ☐Tiring/Exhausting
☐Tingling/Pins and Needles

What word best describes the frequency of your pain? ☐ Constant ☐ Intermittent
When is your pain at its worst? ☐Morning ☐During the day ☐ Evenings ☐Middle of the night

---

PAIN HISTORY/DESCRIPTION

Which activities or body positions bring on or <u>WORSEN</u> your pain?

☐Sitting ☐Standing ☐Walking ☐Lying down on back ☐Lying down on belly

☐Lifting _____ ☐ Coughing/Sneezing ☐Hot/Cold Weather ☐Damp Weather

☐Bowel Movements ☐Exercise ☐Other: _____

_____

If your pain is worse with walking, does leaning forward (such as on a shopping cart) help lessen the pain or allow you to walk further? Yes No

Which activities or body positions seem to <u>IMPROVE</u> your pain (even if temporarily)?

☐Sitting ☐standing ☐Walking ☐lying down on back ☐lying down on belly

☐Bed Rest ☐Bringing knees to chest ☐Hot Packs/Shower ☐Cold Packs

☐Meditation/ Relaxation ☐Other: _____

Which <u>SYMPTOMS</u> are associated with your pain? Check ALL that apply:

☐Weakness of arm(s) – Left / Right / Both ☐Numbness of arm(s) – Left / Right / Both

☐Weakness of leg(s) – Left / Right / Both ☐Numbness of arm(s) – Left / Right / Both

☐Lots of morning stiffness ☐Loss of bladder or bowel control

☒Tenderness at the affected area ☐Coolness or pale skin ☐Discolored or blotchy skin

☐Impotence ☐Decreased sex drive ☐Depression ☐Headaches ☐Fever

☐Pain with very light touch ☐Weight gain (How many pounds in the past 6 months? _____)

☐Weight loss (How may pounds in the past 6 months? _____)

☐Difficulty sleeping ☐Have to sleep in recliner/chair now ☐ Pain awakens you at night

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How does the pain affect your lifestyle? (What can you no longer do because of your pain condition?)
Describe: _____

_____

In the past three months, have you developed any new:

☐Balance Problems ☐Loss of bladder control ☐Bowel Incontinence ☐Chills

☐Difficulty Walking ☐Fevers ☐Nausea ☐Vomiting

☐Numbness/Tingling – Where? _____ ☐Weakness – Where? _____

☐I HAVE NOT RECENTLY DEVELOPED ANY OF THE ABOVE PROBLEMS.

Diagnostic Test and Imaging

Mark all of the following tests you have had that are related to your current pain complaints:

MRI of the: _____ Date: _____ Facility: _____

X-ray of the: _____ Date: _____ Facility: _____

CT scan of the: _____ Date: _____ Facility: _____

EMG/NCS of the: _____ Date: _____ Facility: _____

Other diagnostic testing: _____

☐I HAVE NOT HAD ANY DIAGNOSTIC TEST PERFROMED FOR MY CURRENT PAIN COMPLAINTS.

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Pain Treatment History

Check the following pain treatments you have undergone prior to today's visit FOR THIS ISSUE:

☐Chiropractic Helpful? Y/N ☐Physical Therapy Helpful? Y/N

☐Spine Surgery Helpful? Y/N

☐Psychological Therapy Helpful? Y/N ☐Podiatrist Treatment Helpful? Y/N

☐Discogram – (circle all levels that apply) Cervical/ Thoracic / Lumbar Helpful? Y/N

☐Epidural Steroid Injection – Cervical / Thoracic / Lumbar Helpful? Y/N

☐Joint Injection – List joint(s) Helpful? Y/N

☐Medial Branch Blocks or Facet Injections – Cervical /Thoracic / Lumbar Helpful? Y/N

☐Radiofrequency Ablation – (circle all levels that apply) Cervical/Thoracic/Lumbar Helpful? Y/N

☐Nerve Blocks – Area/Nerve(s) Helpful? Y/N

☐Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant Helpful? Y/N

☐Trigger Point Injection – What area? Helpful? Y/N

Medications: CIRCLE all that you have tried.

NARCOTICS: hydrocodone (Vicodin, Norco, Lortab), oxycodone (Roxicodone, Percocet), OxyContin, tramadol (Ultram), hydromorphone (Dilaudid, Exalgo), oxymorphone (Opana), morphine (MS Contin, Kadian, Avinza, Embeda), methadone, tapentadol (Nucynta), fentanyl (Duragesic, Actiq, Fentora), Burprenorphine (BuTrans, Subutex, Suboxone).

Nerve Pain: gabapentin (Neurontin), Lyrica, carbamazepine (Tegretol), oxcarbazepine (Trileptal), amitriptyline (Elavil), nortriptyline (Pamelor), duloxetine (Cymbalta), milnacipran (Savella).

INFLAMMATION: ibuprofen, naproxen, diclofenac, Celebrex, meloxicam (Mobic), Toradol

MUSCLE RELAX: cyclobenzaprine (Flexeril), tizanidine (Zanaflex), baclofen, Skelaxin, methocarbamol (Robaxin), Norflex, carisoprodol (Soma)

☐**I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN**

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Past Medical History

CHECK the following conditions/diseases that you have been treated for currently or in the past:

Stroke ☐ Y ☐ N	Osteoporosis ☐ Y ☐ N	Tuberculosis ☐ Y ☐ N
Heart Trouble ☐ Y ☐ N	Seizures ☐ Y ☐ N	Phlebitis ☐ Y ☐ N
High Blood Pressure ☐ Y ☐ N	Mental Illness ☐ Y ☐ N	Anemia ☐ Y ☐ N
Heart Valve ☐ Y ☐ N	Neuropathy ☐ Y ☐ N	Acid Stomach ☐ Y ☐ N
Diabetes ☐ Y ☐ N	Kidney Problems ☐ Y ☐ N	Stomach Ulcers ☐ Y ☐ N
Osteoarthritis ☐ Y ☐ N	Kidney Stones ☐ Y ☐ N	Liver Trouble ☐ Y ☐ N
Rheumatoid Arthritis ☐ Y ☐ N	Alcoholism ☐ Y ☐ N	Thyroid Trouble ☐ Y ☐ N
Gout ☐ Y ☐ N	Hepatitis ☐ Y ☐ N	Bleeding Disorder ☐ Y ☐ N
Are you pregnant? ☐ Y ☐ N	Lung Disease ☐ Y ☐ N	Blood Clots ☐ Y ☐ N
Cancer ☐ Y ☐ N	Serious Injuries ☐ Y ☐ N	Blood Transfusions ☐ Y ☐ N
Type of Cancer_____	HIV or AIDS ☐ Y ☐ N	Other_____
Metal Allergy/_____	Infection or MRSA ☐ Y ☐ N	

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Abdominal Surgery

☐Gallbladder Removal

☐Appendectomy

☐Other_____

Female Surgeries

☐Caesarean Section

☐Hysterectomy

☐Laparoscopy

☐Ovarian

Joint Surgery

☐Shoulder R or L When _____

☐Hip R or L When _____

☐Knee R or L When_____

Spine / Back Surgery

☐Discectomy: Cervical / Thoracic / Lumbar

☐Laminectomy: Cervical / Thoracic / Lumbar

☐Spinal fusion: Cervical / Thoracic / Lumbar

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Heart / Brain Surgery

☐Valve Replacement

☐Aneurysm Repair

☐ Stent Placement

☐Other_____

Other Surgeries

☐Hemorrhoid Surgery

☐Hernia Repair

☐Thyroidectomy

☐Tonsillectomy

☐Vascular Surgery

Please list any other surgeries and dates (attach an additional sheet if necessary)

_____

_____

_____

☐I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE.

Allergies

Do you have any known drug allergies? ☐Yes ☐No

If so, please list all medication you are allergic to.

Medication Name	**Describe the Reaction**

Specific Allergies: ☐Iodine ☐Latex ☐Tape ☐Band-Aids ☐IV Contrast

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Current Medication

Are you currently taking any BLOOD THINNERS? _____

Please list ALL medication you are currently taking. Attach an additional sheet, if needed.

MEDICATION NAME DOSE FREQUENCY MEDICATION NAME

_____

_____

_____

_____

Family History

Mark all appropriate diagnoses as they pertain to your biological PARENTS and SIBLINGS only.

☐Arthritis/Joint Pain	☐Mother	☐Father	☐Sibling	☐Grandmother/ Grandfather
☐Nerve Pain	☐ Mother	☐Father	☐Sibling	☐Grandmother/ Grandfather
☐Back Pain	☐ Mother	☐Father	☐ Sibling	☐ Grandmother/ Grandfather
☐Muscle Pain	☐ Mother	☐Father	☐Sibling	☐Grandmother/ Grandfather
☐Headaches	☐Mother	☐ Father	☐ Sibling	☐ Grandmother/ Grandfather
☐High Blood Pressure	☐Mother	☐Father	☐Sibling	☐Grandmother/ Grandfather
☐Heart Disease	☐Mother	☐Father	☐Sibling	☐Grandmother/ Grandfather
☐Kidney Problems	☐ Mother	☐Father	☐Sibling	☐Grandmother/ Grandfather
☐Liver Problems	☐Mother	☐Father	☐Sibling	☐Grandmother/ Grandfather
☐Osteoporosis	☐Mother	☐ Father	☐Sibling	☐Grandmother/ Grandfather
☐Cancer	☐Mother	☐ Father	☐Sibling	☐Grandmother/ Grandfather
☐Seizures	☐Mother	☐ Father	☐ Sibling	☐ Grandmother/ Grandfather
☐Diabetes	☐ Mother	☐ Father	☐Sibling	☐ Grandmother/ Grandfather
☐Stroke	☐Mother	☐Father	☐ Sibling	☐ Grandmother/ Grandfather

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Other medical problems: _____

☐I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY.

☐ I AM ADOPTED (No Medical History Available)

Social History

Are you capable of becoming pregnant? ☐Yes ☐No

If so, are you currently pregnant? ☐ Yes ☐No

Highest level of education: ☐Grammar School ☐High School ☐College ☐Post-Graduate

Alcohol Use: ☐Daily Limited ☐History of Alcoholism ☐Current Alcoholism

☐Never Drink Alcohol ☐Drinks Alcohol Socially

Tobacco Use: ☐ Current tobacco user ☐Former tobacco user ☐Never Used Tobacco

Illegal Drug Use: ☐denies any illegal drug use

☐Currently using illegal drugs (Which :_____)

☐Currently uses marijuana

☐Currently using someone else's prescription meds

Formerly used illegal drugs (not currently using) (Which :_____)

Have you ever abused narcotic or prescription medications? ☐Yes ☐ No

(Which :_____)

Are you currently employed? ☐ Yes ☐No

If yes, where? _____

What kind of activity does this entail? _____

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Review of Systems

CHECK the following symptoms that you CURRENTLY suffer from. ***Note***: Diagnosed conditions/diseases should be noted under the Past Medical History section above.

Constitutional: ☐Unexpected Weight Loss ☐Weight Gain ☐Fever☐Chills ☐Fatigue

Eyes: ☐Corrective Lenses ☐ Blurred or Double Vision ☐Eye Pain ☐ Redness ☐Watering

ENT: ☐Headache ☐Difficulty ☐Swallowing ☐Nose Bleeds ☐Ringing in Ears ☐Earaches

Cardiovascular: ☐Chest Pain ☐ Palpitations ☐Fainting ☐ Murmurs

Respiratory: ☐Short of Breath ☐Wheezing ☐Cough ☐ Tightness ☐ Inspiration Pain ☐Snoring

Gastrointestinal: ☐Heartburn ☐ Nausea ☐Vomiting ☐Constipation ☐Diarrhea ☐ Bloody/Tarry Stools

Genitourinary: ☐Frequency ☐Urgency ☐ Difficult or Painful Urination ☐Flank Pain ☐Bleeding

Musculoskeletal: ☐Joint Pains ☐Swelling ☐Instability ☐Stiffness ☐Redness ☐Heat ☐ Muscle Pain

Skin: ☐Skin Changes ☐Poor Healing ☐Rash ☐ Itching ☐ Redness

Neurologic: ☐Numbness or Tingling ☐Unsteady Gait ☐Dizziness ☐Tremors ☐Seizure

Psychiatric: ☐Nervousness ☐Anxiety ☐Depression ☐Hallucinations

Hematologic: ☐Easy Bleeding ☐ Bruising

Endocrine: ☐Excessive Thirst or Urination ☐ Heat Intolerance ☐Cold Intolerance

Allergic: ☐Reaction to foods or environment

If marked above, have you discussed the problem with your primary doctor? Yes No

Signature and Date

I certify that the above information is accurate, complete and true.

Signed: _____ Date: _____

Reviewed by Physician: ☐

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Appointment Reminder Consent

Please complete this form to allow Huntsville Pain Management to provide appointment reminders by email and cell phone text message.

Patient Name: _____

Email Address: _____

Mobile Number: _____

Phone Carrier: _____

I recognize that normal text messaging rates may apply. It is important to note that text messages and emails are generated by using a secure service. However, they are transmitted through a public network to your personal phone. You may opt out of either of these services at any time by written request. Please keep the practice informed of your up to date mobile number and email address.

Signature: _____ Date: _____

If you do not wish to participate in either of these services, please write REFUSE SERVICE below. Please understand that if you do refuse this service you will not receive reminder notifications about any future appointments and will be subjected to a $50 fee for any missed appointments or arriving 20 minutes past appointment time.

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Informed Consent for Trigger Point Injections / Intramuscular Stimulation (IMS)

Trigger point injections (TPI) is used to treat painful and tender areas of muscle. Normal muscle contracts and relaxes when it is active. A Trigger point is a discrete knot or tight, ropy band of muscle that forms when muscles fail to relax. The knot often can be felt under the skin and may twitch involuntarily when touched. In a trigger point injection a small needle is inserted into the trigger point and a local anesthetic (e.g. lidocaine, procaine, and bupivacaine) or anti-inflammatory is injected. IMS uses a fine and flexible needle to release shortened bands of muscle. No drugs are injected during IMS. Insertion of the needle inactivates the trigger point and thus alleviates pain. Additional treatment may be needed to achieve sustained relief.

The details of the procedure have been explained to me in terms I understand and alternative methods and their benefits and disadvantages have been explained to me. I understand and accept that there are complications, including the remote risk of death or serious disability that exists with any surgical procedure.

I understand and accept the most likely risks and complications of trigger point injections and IMS, which include but are not limited to:

-General Disappointment
-Needle Breakage
-Trauma to Nerves
-Vasovagal Reaction (fainting)
-Infection
-Numbness
-Pneumothorax with chest wall injections
-Soft tissue swelling,bruising,or hematoma formation

Any time a needle is used there is a risk of infection. Huntsville Pain Management uses new disposable sterile needles and infection is rare.

I understand and accept the anticipated outcomes:

-Increased circulation to the muscles
- Increased pain threshold at the trigger point
-Pain reductions
-Temporary increased muscle spasm
-Increased exercise tolerance
-Increased range of passive and active motion
- Multiple sessions necessary
- Temporary injection and post-injection pain

I have informed the physician of all my known allergies. I have informed the doctor of all medications I am currently taking, including prescription drugs, over the counter remedies, herbal therapies and supplements, aspirin and any other recreational drug or alcohol use. I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure. I have informed practitioners about conditions such as pregnancy, pacemakers, or the use of blood thinners prior to treatment.

I have been informed of what to expect in the post-injection period, including but not limited to: estimated recovery time, anticipated activity level and the possibility of additional procedures. The physician has answered all of my questions regarding this procedure. **I certify that I have read and understand this treatment agreement prior to my signature.**

I authorize and direct Dr. James Thacker, with associates or assistants of his choice, to perform the procedure of trigger point injections and Intramuscular stimulation on _____(name). I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

Signature Patient or Legal Representative	Print Name	Date
Signature of Staff	Title	Date

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Medical Photography Consent Form

I, _____consent to medical images and/or video being made of me or my child/dependent.

I agree that the images below may be:
(Please check your answer below to show consent.)

	Yes	No
• Placed in my medical record for future treatment	____	____
• Electronically emailed to my treating health professional	____	____
• Used by health professionals for education and training	____	____
• Used in paper or electronic health publications	____	____
• Used in commercial broadcast	____	____
• Used in marketing materials	____	____

By signing below, I confirm that I understand this consent form.

_____ _____
Signature of Patient/ Parent or Guardian Date

_____ _____
Signature of Staff Date

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Pre-Authorizations (PAs)

Effective January 1, 2023:

The number of Pre-Authorizations (PAs) that are being required by YOUR Insurance Companies to cover your medications has increased to the point that our staff is having to stay after Clinic ours to accommodate this requirement.

Due to additional time that it takes to fill out the forms and the follow-up phone calls, we are implementing a charge of $15 per PA. This is not a charge that your Insurance Company will pay; you will need to pay this charge.

We will also be charging for any forms or letters that will be needed for work, housing, FMLA, etc. This fee will be a flat rate of $25. This does not include Handicap Placard forms or work/school excuses.

Please select one check-box below, sign, and date.

☐ I understand and agree that I will be charged a flat fee of either $15 for each PA or $25 for forms and letters.

_____ _____
Patient Name/Date of Birth Date

_____ _____
Witness Name Date

☐ I have chosen **NOT** to pay the $15 Pre-Authorization (PA) charge for the $25 form fee. I understand that my medication may not be paid for by my insurance and that I will either have to pay the full price of that medication or be changed to a medication that my insurance will cover based on their formulary list.

_____ _____
Patient Name/Date of Birth Date

_____ _____
Witness Name Date

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(HIPAA) Individual Patient's Authorization

Name_____DOB_____Social Security Number_____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described below are not health plans, health care providers or healthcare clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand I have the right:

- To inspect or copy the protected health information to be used or disclosed
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations- and the organization is not required to agree to the restrictions requested
- To refuse to sign the authorization
- To a statement that covered entity may receive remuneration from us or disclosure of requested information
- To a copy of this form

I understand that I may revoke this authorization at any time by giving a written notice. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization or if the covered entity had taken action in reliance thereon. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

Specifically describe the information to be used or disclosed, such as date(s) of service, level of details to be released, origin of information, etc.:_
_____

The information will be used or disclosed for the following purposes ("at the request of the individual" is a sufficient description of the purposes when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose):_____
_____

I request the following restrictions to the use or disclosure of my health information:
_____

Name/Identification of person(s) to whom the covered entity may make the requested use or disclosure:

Expiration date is one year from the date of this form: _____

Signing this authorization is not a condition of treatment. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Individual Patient's Signature
I have had the chance to read and think about the consent of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

_____ I acknowledge receipt of the Notice of Privacy Practices form which details how Protected Health Information may be used and disclosed and how I may access that information.

_____ _____ _____
Signature of Patient or Legal Representative | Date | Witness Signature

185 Chateau Drive, Suite 302
Huntsville, AL 35801
Phone: (256) 885-1605
Fax: (256) 885-1905

Cancellation / No Show Policy / Late Fee

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to cancelling your appointment. **No shows Late Fee** (20 minutes past appointment time), and **cancellations** less than 24-hours will incur a fee of **$50.00** for office visits and **$100.00** for procedures that have been scheduled.

I understand if I no show for two (2) consecutive appointments, no show for three (3) appointments or cancel for a total of three (3) appointments, I may be discharged from care. Huntsville Pain Management, Inc., will notify you in writing, via certified mail, if you are discharged from care. I have read and understand the above information, and I agree to the terms described.

_____ Initials

Self-Pay

IF my health insurance becomes null or void, I will be responsible for services rendered here at Huntsville Pain Management, Inc, the full and entire amount for treatment given to me or the above-named patient at the initial visit, and for each office visit. This is not including any other treatment I may receive. I also understand that urine and/or blood drug screens as well as Behavior Screening will need to be performed according to the practice policies, will be paid in addition to the office visits.

_____ Initials

IN NETWORK INSURANCE

I understand that Huntsville Pain Management, Inc. will file my insurance and that I am responsible for all monies owed that my insurance does not pay. It is my responsibility to understand my policy and my financial responsibilities.

_____ Initials

OUT OF NETWORK INSURANCE

If my insurance is considered out of network with Huntsville Pain Management, I understand that I am responsible for all monies due at the date of service and that Huntsville Pain Management will file my insurance as a courtesy for me. If my insurance does pay Huntsville Pain Management, Inc., I understand that Huntsville Pain Management will reimburse me.

_____ Initials

MOTOR VEHICLE INSURANCE (PIP)

I do not have health insurance. I request my claims be submitted to my motor vehicle carrier. I understand I will be responsible for bills by me in the event my PIP benefit exhausts or denies.

_____ Initials

Patient/Guarantor Signature: _____ Date: _____

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Authorization

Consent for Treatment: I hereby authorize the performance of any medical procedure, which may be advised and/or recommended by my physician.

I authorize the release of any information that may be required or as pertains to my treatment such as operations, consultations, diagnostic test, physical examinations, etc. A photo-copy will be as valid as the original. I authorize payment directly to the undersigned physician of the surgical and/or emergency benefits, including major medical insurance, if any, payable to me. I authorize the release of any information to insurance carriers concerning my diagnosis and treatments and I assign to the physician all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance for this authorization.

If the patient has Medicare: I certify that all the information given to me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of authorized benefits be made on my behalf and assign the benefits payable for physician services to HPM.

If the patient has Medicaid: I certify the information given by me in applying for payment under title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the state of Alabama or its fiscal agents any information needed for this or a related Medicaid Claim. I request that payment of authorized benefits be made on my behalf.

If the patient has Tricare: I hereby agree to accept full responsibility for any co-pays or cost shares that are considered part of my Other Health Insurance (OHI) plan even though making these payments may result in Huntsville Pain Management being paid an amount in the excess of the 115% balance billing limit set by Public Law 102-396. I also understand that Huntsville Pain Management may bill me for any cost share or co-payment that is not paid at the time of service.

I acknowledge I have been given the opportunity to read Huntsville Pain Managements Notice of Privacy Practices.

Patient(or responsible party)_____ Date_____

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Informed Consent & Pain Management Agreement

This form is used by Huntsville Pain Management, Inc. to help create a clear understanding of the rules and expectations that are involved if it is decided that opioid medication(s) ('narcotics') may be indicated as part of your treatment.

If you do not want to include narcotics as a component of your treatment, please initial here:_____You will not need to fill the remainder of this form out.

NAME OF PATIENT:_____DATE:_____

That this is a pain management policy and agreement related to my use of opioids, also called "narcotic," "pain killers", and other prescription medication(s) for chronic pain prescribed by my Huntsville Pain Management (HPM) provider. I understand that there are federal and state laws that have regulations and policies regarding the use and prescribing of controlled substances.

Therefore, medication(s) will only be provided so long as I follow the rules specified in this agreement. My physician may, at any time, choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or may result in my discharge from care and treatment. Discharge may be immediate for any illegal behavior.

- My progress will be periodically reviewed and if the medication(s) are not improving my quality of life, the medication(s) may be discontinued. _____ **Initials**
- I will disclose to HPM all medication(s) that I take at any time, prescribed by any other care provider. If this is my first visit, I will disclose all currently medications prescribed by other care providers prior to my first visit. _____**Initials**
- I will use the medication(s) **exactly** as directed by HPM. Self-medicating and medication escalation without approval will result in DISMISSAL from clinic. _____**Initials**
- I agree **NOT** to share, sell or otherwise permit others, including my family and/or friends to have access to these medications. _____**Initials**
- All medication(s) must be obtained at a single agreed-to pharmacy. Should the need to arise to change pharmacies: my physician must be informed at the next scheduled visit. I will use only one pharmacy.

  I authorize my HPM provider to release my medical records to my pharmacist as necessary. _____**Initials**
- I understand that my medication(s) may be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money: if they are lost or stolen, they **MAY NOT** be replaced. _____**Initials**
- Refill(s) will **NOT** be ordered before the scheduled refill date. However, early refill(s) may be allowed when I am traveling and I have made arrangements **PRIOR** to the planned departure date. Otherwise, I will **NOT** expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescriptions run out. _____**Initials**
- I will receive controlled medication(s) **ONLY** from HPM unless it is for an emergency of the medication(s) that is/are being prescribed by another physician has been approved by my HPM provider. Information that I have been receiving medication(s) prescribed by another doctor that has not been approved may lead to a **discontinuation** of medication(s) and treatment by my HPM provider. _____**Initials**

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- I agree to submit to urine, saliva, and/or blood screens to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for **non-prescribed** medications or prescriptions that are **NOT** current may lead to dismissal from clinic. Testing positive for **illegal substances**, such as, speed, cocaine, meth etc., **WILL** result in **termination** of care. Also, a consult with or a referral to an expert may be necessary; such as submitting to a psychiatric or psychological evaluation by a qualified practitioner such as an addictionologist or a physician who specialized in detoxification and rehabilitation and/or cognitive behavioral therapy/ psychotherapy. _____**Initials**
- I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize that my ***active*** participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program recommended by my HPM physician to achieve increased function and improved quality of life. _____**Initials**
- I agree that I shall inform any doctor or provider who may treat me for other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm. _____**Initials**
- I hereby give HPM permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medication(s) prescribed by my other physician(s). _____**Initials**
- I **MUST** take medication(s) as instructed by HPM. Any unauthorized increase in the dose of medication(s) may be viewed as cause for **discontinuation** of treatment. _____**Initials**
- Refills will be made ***ONLY*** during scheduled appointments. Refills will **NOT** be made over the phone, at night, or on the weekends. **This policy will be strictly adhered to.** _____**Initials**
- Refills will **NOT** be made if I "run out early" or "lose a prescription" or "spill or misplace" my medication. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. _____**Initials**
- I agree that I will submit a **random** urine and or saliva test at least twice a year and when requested by my provider to determine my compliance with and my metabolization of pain control medication(s). Tests will also include screens for illegal substances. _____**Initials**
- I **AGREE** to random pill counts which will require me to be at the office **within an hour** of receiving a phone call. If I fail to attend my pill count, it will be regarded as a positive for non-compliance with medication(s) You are subject for **discharge** from the practice. _____**Initials**
- I understand that I am a patient of Huntsville Pain Management and that I am **NOT** guaranteed to see my specific provider. For the case of scheduling, and to meet insurance contracts, I agree to see any of the HPM providers. _____**Initials**

Patients who have concerns regarding their treatment should call the office at 256-885-1605. Calls will be returned in the order that they are received. Please allow 24 hours for a return phone call.

_____
Patient Signature

_____
Pharmacy of Choice

_____
Pharmacy Phone Number

185 Chateau Drive, Suite 302
Huntsville, AL 35801
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Patient's Bill of Rights

You Have the Right…

- Not to be denied participation in all treatment services based on the grounds of race, color, creed, sex, sexual orientation, national origin, disability, diagnosis, religion, age, socioeconomic status.
- To considerate and respectful care.
- To reasonably expect, from the staff members responsible for your care and welfare, complete and current information concerning your condition.
- To know by name and position the staff members responsible for your care.
- To reasonable consideration of your privacy and to be treated with respect and full recognition of your dignity, individuality, and reasonable cultural needs.
- To expect a reasonable response to your requests.
- To be free from all forms of abuse or harassment, neglect, or exploitation.
- To be reasonably informed at the time of check out of medical and/or ancillary services charges.
- To be afforded the opportunity to participate in planning and implementing your treatment program, to refuse care, treatment or serviced in accordance with law and regulation.
- To the maintenance of confidentiality of your clinical record.
- To access information contained within your medical record.
- To be informed, when appropriate, about the outcomes of care, including unanticipated outcome.

You Have the Responsibility…

- To be honest about matters that relate to you as a patient.
- To provide staff with accurate and complete information about present complaints, past illnesses, hospitalization, medications and other matters pertaining to your health.
- To report any perceived risks in your care.
- To report any unexpected changes in your condition to those responsible for your care and welfare.
- To follow the care, service or treatment plan developed.
- To ask any questions when you do not understand or have concerns about your plan of care.
- To understand the consequences of the treatment alternatives and not following your plan of care.
- To know the staff who are caring for you.
- To be considerate and respectful of the rights of both fellow patients and staff.
- To honor the confidentiality and privacy of other patients.
- To be considerate of the property of Huntsville Pain Management.
- To assure the financial obligations of your healthcare are fulfilled as promptly as possible.

How to File a Complaint

Verbal complaints can be made by calling the main number at 256-885-1605 and asking for the Practice Administrator, Sandra Thacker, or asking in person for the Practice Administrator, Sandra Thacker, while on the premise. Written correspondence addressed to Practice Administrator, Sandra Thacker, will be handled in the same manner. All complaints will be dealt with in a timely manner. In the event that a complaint is not resolved to the satisfaction of the patient or their representative, they may also contact the Clinic Director, Dr. James Thacker