COMPREHENSIVE PAIN CENTER

Welcome to Comprehensive Pain Center!

Welcome to the Comprehensive Pain Center. Our goal is to identify and treat the underlying causes of pain in order to restore the highest level of function and quality of life possible.

Please complete this packet in its entirety so that we may provide you with optimal medical care. Carefully read the agreement for participation and the agreement for medication management. These define the policies of the Comprehensive Pain Center which must be signed in order to participate with this practice.

Please contact the office at (410) 997- PAIN (7246) with any questions.

Thank you,

Mark Matsunaga, M.D.
Comprehensive Pain Center

Patient Information

Name LAST FIRST DOB DD / MM / YYYY SSN # XXX – XX – XXXX

Sex M F Marital Status STATUS Spouse's Name LAST FIRST

Address XXXXX STREET NAME City CITY State XX Zip XXXXX

Home Phone (XXX) XXX - XXXX Cell Phone (XXX) XXX - XXXX E-Mail Address EMAIL@YOUREMAIL.COM

Primary Care MD PMD / PCP Referring MD REFERRING MD

Employer EMPLOYER Occupation OCCUPATION

Employment Status ☐Full Time ☐Part Time ☐Retired ☐ Disabled Student ? ☐ No ☐Full Time ☐Part Time

Insurance Information

	Primary	Secondary
Insurance Company	PRIMARY INSURANCE	SECONDARY INSURANCE
Policyholder Name	PRIMARY POLICYHOLDER	SECONDARY POLICYHOLDER
Member ID / Group / Policy #	PRIMARY ID / GROUP / POLICY	SECONDARY ID / GROUP / POLICY

Emergency Contact

Name NAME Relation E.G. SPOUSE Phone # (XXX) XXX - XXXX

Acknowledgement and Consent

I acknowledge that I have received a copy of the Comprehensive Pain Center's notice of Privacy Practice (Page XXX of XXX). By signing this form, I consent to the Comprehensive Pain Center use and disclosure of protected health information about me for treatment, payment, and health care operations. I understand that I have the right to revoke this consent in writing, except where the Comprehensive Pain Center has already made disclosures in trust on my prior consent.

Signature Date

Please list family members or others with whom we may discuss your medical information or account information. Please designate by your "X" in the appropriate column, which information we may discuss with each party listed.

Name	Relationship	Medical	Account

Medical History

If there is not space in any section, please write on back of page or attach list.

Allergies

Please list all allergies, medication or other.

Medication or Other Substance	Type of Reaction

Current Medications

Please list <u>all</u> medications you are currently taking.

Name	Dosage	Frequency	Side Effects

Past Medical History

Please list all current and past medical concerns.

Surgical History / Hospitalizations

Please list all past surgical procedures and hospitalizations.

Surgery / Hospitalization	Date	Surgery / Hospitalization	Date

Family History

Please list any and all family medical history, e.g. cancer, high blood pressure

Illness	Relationship	Approx. Age When Diagnosed

Social History

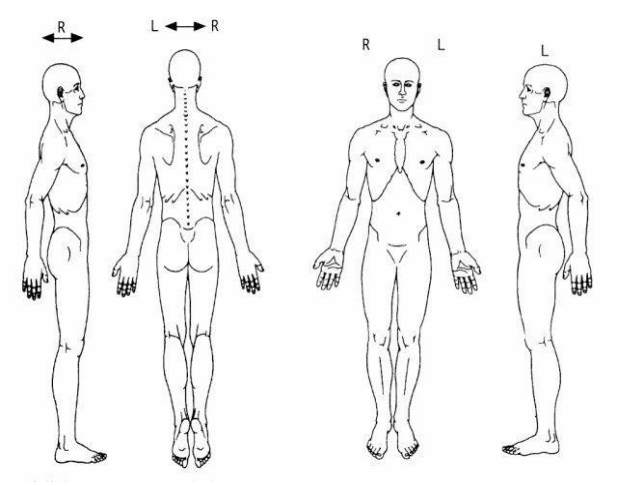
Do you smoke?		Do you drink?
Everyday Smoker	Someday Smoker	Yes
Former Smoker	Never Smoker	No
Packs Per Day?		Drinks Per Week?

Do you drink coffee / tea?		Do you use recreational drugs?	
Yes	No	Yes	No
Cups Per Day?		Type:	
		Frequency:	

Have you ever worked with hazardous materials?		Are you in a relationship where you have been physically hurt or feel afraid?	
Yes	No	Yes	No
If Yes, explain:		If Yes, explain:	

Current Medical Condition

Where is your pain?



When did it start? e.g. months, years

How do you rate your level of functioning?

Poor Adequate Fair Good

What is the **range** of your pain on a given day?

0 1 2 3 4 5 6 7 8 9 10

How do you describe your pain?	What makes your pain worse?	What makes your pain better?
Constant	Activity	Rest
Intermittent / Occasional	Sitting	Sitting
Local	Standing	Laying Down
Diffuse	Bending Forward	Fetal Position
Radiating	Bending Backward	Bending Backward
Sharp	Sitting to Standing	Bending Forward
Dull	Time of Day AM PM	Ice
Burning	Hot	Heat
Numbing / Tingling	Cold	Activity
Other:	**Other:**	**Other:**

Do you experience any of the following neurological symptoms?

Numbness Tingling Bladder incontinence

Bowel Incontinence Weakness Balance Problems

Radicular Pain (pain that radiates into a limb) If so, where: _____

Past Treatment for Current Medical Condition

Past Medications

Please list <u>all</u> medications related to your pain that you have taken in the past.

Name	Dosage	Frequency	Side Effects

Past Treatments / Interventions

Please list all past treatments related to your current medical condition, e.g. injections, surgery, PT

Please indicate the level of relief from your treatment: None, Poor, Adequate, Fair, Good

Treatment	Relief?	Treatment	Relief?

Past / Current Specialists

Please list <u>all</u> specialists you are seeing or have seen in relation to your current medical condition.

Name	Specialty	Currently Treating?

Diagnostic Studies

Please list all past diagnostic studies related to your current medical condition, e.g. CT, MRI, EMG

Diagnostic Study	Date	Diagnostic Study	Date

Participation Agreement

1. We request payment or co-payment and a valid referral form for services at the time service is rendered. If you require a procedure, we will file an insurance claim on your behalf. We will bill you for the portion of the fee that is not covered by your insurance. I hereby authorize the Comprehensive Pain Center to apply on my behalf for covered services rendered. I request payment from my insurance carrier(s) of record be made directly to the Comprehensive Pain Center. I certify that I have reported correctly with regard to my insurance coverage and further authorize the release of any necessary information, including medical information for this or related claims to my insurance carrier(s) of record. I permit a copy of this authorization to be used in place of the original.

2. I will arrive to my appointments ten minutes early to allow time for check-in. If more than **15 min late**, my appointment may be rescheduled, and with no notification, I may be charged a missed appointment fee ($50 for an office visit, $75 for a procedure). I will be responsible for obtaining my referrals for my office visits and procedures. If I do not have my referral(s)/approval(s), I may not be able to see the practitioner. If I do need to reschedule, **24-hour notification is required.** Appointment reminder phone calls are not made by Comprehensive Pain Center.

3. I will comply with the recommended diagnostic evaluations, therapeutic interventions and ongoing recommendations for optimal medical care outcomes. I understand that weight management is an essential and crucial aspect of my treatment plan and failure to comply with weight management plans.

4. I will be responsible for financial obligations which will include co-pays, fees and other charges. They are due prior to the visit with the Comprehensive Pain Center practitioner. I realize I may not be permitted to continue with the care of the Comprehensive Pain Center if I am not responsible with my financial liabilities. I will provide all necessary information to bill my insurance company and keep the Comprehensive Pain Center informed about any changes in insurance coverage.
    a. **Self-Pay Rates**: Initial Office Consult $500; Follow-up $200; Procedure $400
    b. **Medical Records**: $22.88 (prep fee) + 76¢ per page + Shipping
    c. **Medical Forms / Opinions**: $300 (not part of typical treatment)

5. I will restrict phone calls and messages to normal office hours. I will not call for non-emergencies on evenings or weekends. If I do have a medical emergency, I will go the ER and have the ER doctor phone the Comprehensive Pain Center as indicated. I will notify the Comprehensive Pain Center of any narcotic prescriptions that I may obtain from the hospital visit.

6. I give permission for the Comprehensive Pain Center to take photographs of me for identification purposes only. I also give consent to have my photo taken if my pain condition would benefit from monitoring the treatment with photographs. These photographs will be for the use of the Comprehensive Pain Center only.

Printed Name	Signature	Date

CAREFULLY READ THE ENTIRE AGREEMENT

Controlled substances such as narcotic pain medications may be prescribed to manage pain. While it is always the goal to control pain to improve quality of life, controlled substances can be dangerous. Controlled substances will only be prescribed with the following agreement between patient and practitioner:

Risk of Controlled Substances

1. **Sedation / Respiratory Depression** - I understand that taking more medication than prescribed can cause sedation and respiratory depression which can be life-threatening.
2. **Tolerance / Addiction** - I understand that controlled substances have a potential for tolerance and addiction, and understand the difference.
    a. *Tolerance* is a natural decrease in a medication's effect when taken long-term and may require incremental increases in medication dosage.
    b. *Addiction* is the use of medications in a compulsive manner to create a euphoria or heightened mood despite adverse consequences.
3. **Withdrawal** - I understand that not taking medications as prescribed may be dangerous and lead to withdrawal symptoms such as *seizures, cramps, sweats, chills, and aches.*
4. **Impaired Function** - I understand that controlled substances can impair my ability drive, perform intricate tasks, and make important decisions. I will avoid driving while starting or adjusting medications. I will adhere to the recommendation of the medications' manufacturer.
5. **Side Effects** - I understand that new medications, changes to medications, and changes in my medical condition can cause unwanted side effects such as nausea, vomiting, sedation, itching, constipation, and allergic reaction.
6. **Alcohol Use / Other Medications** - I understand that alcohol use with controlled substances can cause respiratory depression, which can be life-threatening. Taking medications such as other opioids, benzodiazepines, or barbiturates can cause over sedation, loss of consciousness, and respiratory depression. Taking medications such as nalbuphine, pentazocine, or buprenorphine may act to reverse one or more medications and lead to withdrawal.
7. ***Men* - Testosterone** - I understand that long-term opioid use can cause low testosterone which can cause changes in mood, stamina, and sexual desire.
8. ***Women* - Pregnancy** - I understand that if I am pregnant or plan on becoming pregnant, opioid use will result in tolerance to opioids in the baby and could be life-threatening in cases of withdrawal. Birth defects, although rare, are also possible.
9. **Abuse** - I understand that people abuse controlled substances by not taking the medications as prescribed or selling / giving their medications to other people.
10. **I affirm that I have full right and power to sign and be bound by this agreement. I have read, understand, and accept all its terms.**

Printed Name	Signature	Date

Policies to Reduce Risks

1. **Education on Dangers of Controlled Substances** - I understand that controlled substances are potentially dangerous, have been informed of and understand all the aforementioned dangers of controlled substances.
    1. **Attendance to *Understanding Pain Management* –** I understand that I may be required to attend a group education session covering general pain education, managing expectations, understanding abuse / addiction, coping mechanisms, etc. with staff psychologist Joseph Eisenberg PhD.
2. **One Pain Practitioner** - I understand that all controlled substances should come from my pain practitioner at OACM/CPC. If prescriptions filled elsewhere I am responsible for notifying my pain practitioner.
3. **One Pharmacy** - I understand that I must use only one pharmacy to fill my controlled substance prescriptions.
4. **No Early Refills** - I understand that I must take my medication as prescribed. Early refills due to running out early, lost / stolen medication is unacceptable.
5. **Random Urine Toxicology** - I understand that I may be randomly selected to provide a urine sample for testing to ensure appropriate medication management.
6. **Keep Safe and Secure** - I understand that my medications are my responsibility. Lost / stolen medications will not be replaced. Be sure to keep medications away from children.
7. **No Diversion** - I understand that I cannot share my medications, sell my medication, or otherwise permit access of others to my medication.
8. **Attend Appointments** - I understand that in order to receive a controlled substance, I must attend my appointment and will not be prescribed medication otherwise.
9. **Communication** - I understand that I must communicate any changes to my medication or medical condition to my practitioner.
10. **Medication Switch** - I understand that if I wish to switch medications for any reason, I must return my current prescription.
11. **Follow Treatment Plan** - I understand that I must adhere to the full treatment plan recommended by my practitioner, not just medication management.
12. **Background Check** - I understand that my practitioner may access criminal background, past pertinent medical history, or a prescription drug monitoring programs (e.g. CRISP).
13. **Post-Dated Prescriptions** - I understand that if I cannot make my appointment due to vacation, illness, or other emergency, my prescriptions will be post-dated.
14. **All Questions Answered - I affirm that I have full right and power to sign and be bound by this agreement. I have read, understand, and accept all its terms. I understand that violation of any policy is grounds for discontinuing treatment at my practitioner's discretion.**

Printed Name	Signature	Date

Release of Records

Release CPC Records to Someone Else

Allows CPC to Send Records to your Referring Doctor, Primary Care, Attorney, etc.

I hereby authorize and request that Comprehensive Pain Center release to the below named physician, attorney, or institution copies of my medical records. I am also permitting you to share my medical information dealing with my pain management care to others who are trying to help me with my painful condition. This authorization is valid for any and all information related to past and present medical history, diagnosis and management. It is also valid for one year and automatically renews every year unless I otherwise specify, in writing, stating my desire to not share my medical information. I understand that the medical records to be released may contain information related to HIV status, AIDS, sexually transmitted diseases, alcohol or drug use, or mental health services, and I hereby authorize the release of this potentially pertinent information.

Release Medical Information
To: _____

_____

_____

Printed Name _____ Signature _____ Date _____

Release of Others' Records to CPC

Allows CPC to Receive Records from your Referring Doctor, Primary Care, Attorney, etc.

I request that release my medical records to Comprehensive Pain Center as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations. I am authorizing release of any and all medical records, including records obtained from other medical professionals and/or organizations. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Printed Name _____ Signature _____ Date _____

Release of Pharmacy Records

Allows CPC to Obtain your Prescriptions Fill History

I request that my pharmacy release my medication history to Comprehensive Pain Center as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and Department of Health and Human Services regulations. I am authorizing release of any and all records requested. I understand that after the pharmacy discloses my medication information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization, however, refusal to sign this agreement will disqualify me from receiving narcotic prescriptions for treatment of chronic pain symptoms. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Printed Name _____ Signature _____ Date _____

Privacy Practice

The Law Sets Rules and Limits on Who Can Look at and Receive Your Information

To make sure that your information is protected in a way that does not interfere with your health care, your information can be used and shared

- For your care coordination
- To pay doctors and hospitals for your health care and help run their business
- With your family, relatives, friends or others you identify who are involved with your health care or your health care bills, unless you object
- To make sure doctors give good care and nursing homes are clean and safe
- To protect the public's health such as by reporting when the flu is in your area
- To make required reports to the police, such as reporting gunshot wounds

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot

- Give your information to your employer
- Use or share your information for marketing or advertising purposes
- Share private notes about your mental health counseling sessions

The Law Gives You Rights Over Your Health Information

Providers and health insurers who are required to follow this law must comply with your right to

- Ask to see and get a copy of your health records
- Have corrections added to your health information
- Receive a notice that tells you how your health information may be used and shared
- Decide if you want to give permission before your health information can be used or shared for certain purposes, such as for marketing
- Get a report on when and why your health information was shared for certain purposes
- If you believe your rights are being denied or your health information isn't being protected, you can
  - File a complaint with your provider or health insurer
  - File a complaint with the U.S. government

You should get to know these important rights, which help you protect your health information. You can ask your provider or health insurer questions about your rights. You can also learn more about your rights, including how to file a complaint, from the website at
www.hhs.gov/ocr/privacy
or by calling
1-866-627-7748; the phone call is free.