Integrity Regional Pain Center

"Get More Out of Life with Integrity"

PLEASE PRINT

Date: _______________

____

Last Name **First Name** **Middle Initial**

____ _____________________________________

Previous Name(s): e.g. Maiden **Nick Name:**

Have you ever been a patient of Integrity Regional Pain Centers at any of our offices before? **Yes __ No__**

If yes, Where/When: ____

____

Home Address: **Apt #:**

____

City **State** **Zip Code**

____

Mailing Address (if different than home, e.g. P.O. Box)

Home Phone: _________________________ **Other Phone**: __________________________

May we leave messages regarding test results, appointments and billing questions on your answering machine?
Yes ___ No___

SSN: ______________________ **DOB**: _________________ **Gender** Male Female

Check one:
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other

Check one:
Race: ☐ Black or African American ☐ American Indian/Alaskan Native ☐ Hispanic ☐ Asian/Pacific Islander
☐ Native Hawaiian or other Pacific Islander ☐ White –Non-Hispanic ☐ Asian ☐ Patient Refusal

Check one:
Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Patient Refusal

Check one:
Primary Language: ☐ English ☐ Spanish ☐ Other: (Please state) _________________________

Check one:
Employment Status: ☐ Active Duty Military ☐ Disabled ☐ Employed Full-Time ☐ Employed Part-Time
☐ Homemaker ☐ Not Employed ☐ Retired ☐ Self Employed ☐ Student ☐ Other

____

Employer Name/Address/phone number:

Primary Care Physician: ______________________________Ph #: ____________________
Date of last visit: _______________________

Referring Physician: ______________________________ Ph #: ______________________
Date of last visit: _______________________

Primary Insurance:

Ins. Co. Name______________________________ Effective Date:

Policy/ID #: ______________ Group #: ____________
Relation to Patient: _____________ Insured's Name: ____________________________
Insured's Date of Birth: _______________ M / F Insured's SS# __________________
Insured's Employer: _________________________

Secondary Insurance Company:

Ins. Co. Name______________________________ Effective Date: ________________

Policy/ID #: ______________ Group #: ____________________________
Relation to Patient: _____________ Insured's Name: ____________________________
Insured's Date of Birth: _______________ M / F Insured's SS# __________________
Insured's Employer: _________________________

Work Comp Injury: ☐ No ☐ Yes (Complete the following)

Date of Injury: _______________
Employer at Time of Injury: ____

Address: ____
City State Zip Code

Contact Person for Work Comp (not employer): ____________________ Contact Person Ph #_____________

Case Number: _____________________ Primary Diagnosis of Injury: _____________

Work Comp Attorney: ______________________________ Ph#: _____________________

Emergency Contact Info: ____
Name/Relationship to Patient **Phone Number**

Section II – Patient General Health Information

Reason for today's visit: ____

Do you have any physical disabilities? (e.g. amputation, loss of vision, speech, hearing; use of arms, legs)

____

Have you had any accidents? (e.g. falls, automobile, etc.) Yes _____ No _____
If yes, is the accident related to your current pain? Yes _____ No _____
If yes, please describe accident:

Type of Accident	Date Occurred	Problem/Symptoms/Pain
______________________________	__________________	____________________________

If yes, is there any legal proceeding pending? Yes _____ No _____
(Office Staff, please inform billing office of potential pending legal proceeding immediately)

MEDICATION LIST

Pharmacy Name: ____ Phone #: ______________________________

MEDICATION	STRENGTH	DOSAGE	LAST TAKEN	REASON	PRESCRIBE BY

ALLERGIES:
Are you allergic to any of the following, (If yes please mark the ones that apply)?
Adhesive tape _____ Iodine _____ Latex _____ Contrast Dye _____

Are you allergic to any medications or non-medications (foods etc)?
If yes, please list below and the reaction/side effect.

Medication Name:	**Reaction/Side Affect**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Non- Medication:	**Reaction/Side Affect**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

<u>Past Medical History (Check all that apply)</u>
Please mark all the following that you have been diagnosed with:

_____ Alcoholism	_____ Depression	_____ Kidney Infections
_____ Allergies/Hay/fever	_____ Diabetes Type 1	_____ Kidney Stone
_____ Anemia	_____ Diabetes Type 2	_____ Migraine
_____ Anxiety	_____ Epilepsy	_____ Multiple Sclerosis
_____ Asthma	_____ Fracture	_____ Obesity
_____ Atrial Fibrillation	_____ Gastric Ulcer	_____ Old MI (previous heart attack)
_____ Blood Transfusions	_____ Gastrointestinal Disease	_____ Osteoarthritis
_____ Coronary Artery Disease	_____ GERD	_____ Osteoporosis
_____ Cancer	_____ Gestational Diabetes	_____ Pneumonia
_____ Cardiac Pacer	_____ Glaucoma	_____ Progressive Neurological Disorder
_____ Cardiovascular Disease	_____ Heart Murmur	_____ Pulmonary Disease
_____ CHF	_____ Hepatitis	_____ Rheumatic Fever
_____ Cirrhosis	_____ High Cholesterol	_____ Rheumatoid Arthritis
_____ Colitis	_____ Hyperlipidemia	_____ STD
_____ COPD	_____ Hypertension	_____ Terminal Illness
_____ CRF	_____ Hyperthyroidism	_____ Thyroid Disease
_____ Crohn's Disease	_____ Hypothyroidism	_____ TIA
_____ CVA	_____ Insulin Pump	_____ Tuberculosis
_____ DVT	_____ Joint Pain	_____ Valvular Problems

Other Medical History:

_____ Bone Cancer
_____ Arthritis
_____ Degenerative Bone Disease
_____ Breast Cancer
_____ Lung Cancer
_____ Prostate Cancer
_____ Shingles
_____ Stroke
_____ Angina
_____ Stomach Ulcer
_____ AIDS
_____ HTV
_____ Cancer, Other type: ___________________________

Hospitalizations:

Please list all hospitalizations for **NON surgical reasons** and dates (if known):

____

____

Tobacco Assessment:

Circle Current Status: Former Smoker Current Everyday Current Some Days Never Smoked

Circle Type used: Cigarettes Smokeless Tobacco Cigars

Circle closest amount of usage per day: ½ pack 1 pack 2 packs 3 packs or more

Social History:

Alcohol Use:
Circle one: Non-Drinker Occasional Social Moderate Heavy Recovering Alcoholic

Circle one: less than 12 drinks a year 1-13 drinks a month 4-14 drinks a week more than 2 drinks a day

Do you use drugs recreationally? _____ Yes _____ No

Mark if you use any of the following recreationally:

_____ Amphétamines
_____ Barbiturates
_____ Cocaine

_____ Codeine
_____ Diazapam
_____ Heroin

_____ Hydrocodone
_____ Marijuana
_____ Morphine

_____ Oxycodone
_____ Soma
Other: _________________________

Dependency or addictions to drugs now or in the past? _____ Yes _____ No
Mark if applicable:

_____ Amphetamines _____ Barbiturates _____ Cocaine

_____ Codeine _____ Diazapam _____ Heroin

_____ Hydrocodone _____ Marijuana _____ Morphine

_____ Oxycodone _____ Soma Other: ________________________

OB/GYN History:
Are you pregnant? _____ Yes _____ No

Mark all that apply:
_____ History of abnormal pap smear _____ Endometriosis

Surgical History:
Please list all surgeries you have had and include dates if known:

____

____

Mental Health:
Are you seeing a mental health professional? _____ Yes _____ No
Mental Health Provider Name: ____

Section III - Review of Systems:

Do you now have, or have you recently had any of the following? (Mark all that apply)
Constitutions:
_____ Fever _____ Chills _____ Unintentional Weight Loss _____ Unintentional Weight gain
_____ Sweats _____ Fatigue _____ Increased appetite _____ Decreased appetite
_____ Other not listed/Comment: ____

HEENT & Neck:
_____ Ringing in the ears _____ Hearing loss _____ Sinus Congestion _____ Blurred Vision
_____ Loss of Vision _____ Frequent Nosebleeds _____ Sore Throat _____ Hoarseness
_____ Snoring
_____ Other not listed/Comment: ____

Respiratory:
_____ Shortness of Breath _____ Wheezing
_____ Cough _____ Requiring Oxygen
_____ Other not listed/Comment: ____

Cardiovascular:

_____ Chest Pain _____ Palpitations _____ Arrhythmia (irregular heartbeat)
_____ Fainting _____ Legs Cramps _____ Swelling of ankles
_____ Other not listed/Comment: ____

Gastrointestinal:

_____ Nausea _____ Constipation _____ Heartburn
_____ Vomiting _____ Diarrhea _____ Abdominal Pain _____ Blood in stool
_____ Other not listed/Comment: ____

Genitourinary:

_____ Frequency _____ Hesitancy _____ Burning on urination
_____ Dysuria (Painful Urination) _____ Kidney Stones _____ Prostate problems
_____ Hematuria (blood in urine) _____ Painful Intercourse _____ Menstrual Complications
_____ Other not listed/Comment: ____

Skin:

_____ Rash _____ Itching _____ Jaundice (yellowing) _____ Other change in skin color
_____ Change in hair or nails _____ Neck has Enlarged _____ Masses (lumps)
_____ Other not listed/Comment:____

Musculoskeletal:

_____ Joint pain _____ Muscle Cramps/Pain _____ Fractures _____ Pain in Back
_____ Walking aids _____ Joint Stiffness _____ Swelling of Joints _____ Pain Neck
_____ Weakness _____ Limitation of use of any joint including back
_____ Other not listed/Comment: ____

Hematologic:

_____ Easy bleeding tendency _____Bleeding disorders _____ Easy Bruising tendency
_____ Bleeding gums
_____ Other not listed/Comment: ____

Endocrine:

_____ Loss of bladder control (polyuria) _____ Hair loss _____ Excessive Thirst (polydypsia)
_____ Loss of bowl control
_____ Other not listed/Comment: ____

Neurological:

_____ Headache _____ Seizures _____ Paralysis
_____ Difficulty walking _____ Confusion _____ Dizziness
_____ Memory lapses or loss
_____ Other not listed/Comment: ____

Psychiatric:

_____ Anxiety _____ Depression

_____ Suicidal Thoughts _____ Suicide attempts _____ Panic attacks
_____ Mood Disorders _____ Emotional Problems _____ Sleep Disturbances
_____ Other not listed/Comment: ____

I certify that the above is true and correct to the best of my knowledge.

_______________________________________ ____________________
Signature of Patient **Date**

Patient Assignment of Benefit and Payment Agreement

Patient Name **(printed):** ____

Thank You for choosing Integrity Regional Pain Center for your pain management needs. We are committed to giving you the best possible pain management care determined to be medically necessary by Integrity Regional Pain Center's Providers. To acquaint you further with the procedures and policies of our clinics, we are providing the following information below.

Insurance Billing: Integrity Regional Pain Center is a Medicare and Missouri Medicaid provider and participates in several other commercial and government payors plans. **Please check directly with your insurance plan in order to ensure our services are a covered benefit and our group/physician is within your specific carrier network of providers.**

Financial Responsibility
I understand insurance billing is a service provided as a courtesy and I am always financially responsible to Integrity Regional Pain Center for any charges not covered by my health care benefits. It is my responsibility to notify Integrity Regional Pain Center of any changes in my health care coverage. I understand I am responsible for the entire bill or balance of the bill as determined by Integrity Regional Pain Center and/or my health care insurer, if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies rendered.
I further agree that in the event I receive any check, draft or other payment subject to services rendered by Integrity Regional Pain Center, I will immediately deliver said check draft or payment to Integrity Regional Pain Center.

Payment of Copays and Balances You are fully responsible for all services provided. Full payment, co-payment and/or deductible amounts are expected at the time of service. Payment may be made by cash or credit card in the offices or by check and money order if mailed. There is a $25 service charge for all personal checks returned for any reason. If you have any questions regarding your account, please speak directly to the billing agency at 636-735-1608.

Please initial: ___________

Assignment of Benefits
I authorize direct remittance of payment of all insurance benefits, including Medicare (if I am a Medicare beneficiary), to Integrity Regional Pain Center for all covered medical services and supplies provided to me during all courses of treatment and care rendered by Integrity Regional Pain Center and/or its affiliated entities. I understand and agree this assignment of benefits will have continuing effect for so long as I am being treated or cared for by Integrity Regional Pain Center and will constitute a continuing authorization, maintained on file with Integrity Regional Pain Center, which authorizes and allows for direct payment to Integrity Regional Pain Center of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care rendered to me by Integrity Regional Pain Center.

Please initial: ___________

Authorization to Release Information
I authorize the release of any medical or any other information to the Health Care Financing Administration, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Integrity Regional Pain Center. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier(s) or other medical entity, if requested. The original authorization will be kept on file by Integrity Regional Pain Center.

Please initial: ___________

Insurance Carrier Referrals: Many insurance carriers require that you obtain a referral prior to your office visit, this includes Missouri Medicaid if you are locked into a provider. In order to make your visit to us as smooth as possible, please check with your insurance plan or your primary care provider about any possible requirement before your appointment.
If you have been referred by another provider, a letter will be promptly sent or faxed outlining our findings and the course of your expected treatment.

Appointments: If you need to cancel an appointment, a minimum of 12 hours advanced notice is required. If you do not call to cancel your appointment you may be subject to a **$50 No Call No show fee**. When the office is closed you may leave a voice message which will accurately record the date and time you called. Our staff will do their best to be punctual for your appointment unless we have an emergency. We ask that you be punctual as well. If you are late for any reason, we will try to work you in if possible. However, you may need to reschedule your appointment for a different day.

After the Initial visit with the Physician, the patient will visit and be re-evaluated at least once a month by the Physician (MD/DO), Physician Assistant (PA) or Nurse Practitioner (NP). All re-evaluation will be scheduled appointments, no walk-in appointments are provided.

Please initial: ___________

Authorization/Pre-certification: Many insurance carriers require that an authorization be obtained prior to your procedures/injections, or diagnostic testing such as MRIs and in many cases for prescriptions. Integrity Regional Pain Center has a precertification/authorization department that handles these requirements. In some cases, these requests can take several days/weeks to be processed in order to obtain authorization/pre-certifications; your patience and understanding is appreciated during this process.

Emergencies: During regular office hours if you call and leave a message for your provider he/she may call you back at their earliest availability, this may be during lunch hour as we must see scheduled patients in the office in a timely manner or the provider may have a member of the staff return your call with directions/instructions.

For emergencies requiring immediate assistance, please call your local emergency provider or 911.

Medical Records: The information contained in your medical records is strictly confidential. We value the trust you place in us to keep this information confidential. If you wish to have a copy of your medical records, please fill out a release form. Once the completed release is received your request will be processed. Please allow at least 30 days for this process. We will send the records to either the requesting facility or the patient, along with an invoice for the copying fee in accordance with Missouri Revised Statue Section 191.227.

My signature below indicates that I agree with the above terms and conditions noted within the "Patient Assignment of Benefit and Payment Agreement". A copy of this document shall be as binding as the document bearing original signature(s).

Patient Signature ____ Date _________________

If patient is unable to sign:

Sign patient's full name: ____

Representative signature: ____ Date _________________

Relationship to patient _____________________________ Representative phone: _________________

Reason patient is unable to sign: ____

AUTHORIZATION FOR RELEASE OF INFORMATION

INTEGRITY REGIONAL PAIN CENTER

Patient Name: ___________________ Date of Birth: ____________________

I understand that Integrity Regional Pain Center (the "Practice) has certain rights and obligations regarding my protected health information (information regarding my health and treatment that the Practice may have in its possession). I also understand that I have certain rights regarding my protected health information.

I authorize the Practice to provide informational reminders regarding upcoming appointments I may have to me or anyone who may answer the telephone, or to leave such reminders on any telephone answering device or service, at the telephone number(s) I have provided the Practice as telephone numbers at which I may be contacted (other than the telephone number of my place of employment) or at any of the following telephone numbers ____.

I authorize the Practice to disclose my protected health information to any of the following persons (state name of person and relationship to you):

____

____

I understand that I may revoke any authorization granted above by written notice signed by me delivered to the Practice's Privacy Official at the address stated below. My authorization remains valid until revoked by me in writing.

I acknowledge receipt of the Practice's Privacy Practices Notice effective January 1, 2020 regarding the Practice's rights and obligations and my rights regarding my Protected Health Information. I acknowledge that I understand that I have the right to request and receive clarifications, explanations or further information regarding The Practice's Privacy Practices through written request signed by me addressed to the Practice's Privacy Official.

Integrity Regional Pain Center
Attn: Ami Politte
P.O. Box 585
DeSoto, MO 63020

____ ______________________

Signature of Patient/Patient's Representative Date:

Basis of representative's authority to act for patient: ____

SPECIFIC
AUTHORIZATION FOR RELEASE OF INFORMATION
INTEGRITY REGIONAL PAIN CENTER

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if any organization authorized to receive the information is not a health plan or health care provider regulated by federal privacy regulations, the released information may no longer be protected by federal or state privacy regulations.

Patient Name: ____________________ SSN ________________ DOB ______________

Organization providing the information: ________________________________.
____
____

Persons/organizations that may receive the information:
_______**Integrity Regional Pain Center**____

***Unless otherwise noted, this Authorization includes an authorization to release any psychotherapy notes or information, records related to sexually transmitted diseases and records related to drug/alcohol abuse.**

Description of information:____
____

Purpose of Disclosure: ____

SECTION B

The patient or the patient's representative must read and initial the following statements:

Initials

_____ **1.** I understand that this authorization will expire ten (10) years from the date listed below.

_____ **2.** I understand that I am not required to sign this authorization and that I may revoke this authorization at any time by notifying the Practice in writing, except the extent that the Practice has taken action in reliance on the consent.

_______________________________________ _________________________
Signature Patient/Patient's Representative Date

____
Printed Name of Patient's Representative

Basis of representative's authority to act for patient: ____
____

Revocations shall be addressed to the Practice's Privacy Official at:
Integrity Regional Pain Center
Attn: Ami Politte
P.O. Box 585
DeSoto, MO 63020
Return requested medical records to: **Integrity Regional Pain Center**

Integrity Regional Pain Center
PAIN MANAGEMENT AGREEMENT

I understand that in order to receive care for the treatment of pain at Integrity Regional Pain Centers, I agree to and will comply with the following:

A. **MENTAL HEALTH**: A mental health assessment and/or continuing psychological therapy may be required. If I am currently involved in mental health therapy**, or a drug treatment program**, or if I enter such therapy, I will authorize my mental health practitioner to exchange unrestricted information regarding my condition and treatment with the health care providers of Integrity Regional Pain Centers.

B. **USE OF MEDICATIONS**: I will take all medications as prescribed. I will speak with a provider of Integrity Regional Pain Centers before making any changes in either the dose or frequency of my medications. I understand that my health status must warrant a change in my medication and that Integrity Regional Pain Center will not authorize early refills of pain medications. I understand that I MUST obtain all narcotic and scheduled pain medications from the same pharmacy (any exceptions must be approved by Integrity Regional Pain Centers).

There will be no change in the patient's medications by telephone. The patient must appear in person and will *NOT* be allowed to change the dosing schedule without prior authorization from the Physician. Only physician(s) will assume responsibility for ALL pain medication and no other type of provider will prescribe them.

If you are having surgery and expect to have a temporary increase in acute pain levels please arrange for a visit after you are discharged from the hospital and we will adjust your medication as needed. **Do not** get extra pain medications from your surgeon (MD/DO) as **this will violate your pain management contract/agreement** with Integrity Regional Pain Centers.

Narcotic Medications are filled on a 28-day cycle. Narcotics will not be filled early in accordance with the DEA and BNDD (Missouri Bureau of Narcotics and Dangerous Drugs) regulations.

If *for any reason* your medication needs to be changed you must bring in your old medication in the bottle so it may be counted by you in front of two Integrity Regional Pain Center staff members. After the completion of the pill count you are required to sign the "Patient Agreement on Medication Disposal". By signing this agreement, you will follow the instructions as given for the proper disposal of the medication(s) and that you will NOT store, sell, give away or trade these medications.

For Non-Narcotic Medications needing to be refilled before your next appointment date, please call our office during normal office hours to request a refill on your medication. Each refill request is carefully reviewed by our medical staff to ensure your safety. Please allow for 24-48 hours to process a refill request.

C. **SEEKING PRESCRIPTIONS**: I will **NOT** seek or fill prescriptions for any medications related to pain relief or muscle relaxers from any other health care provider unless authorized by Integrity Regional Pain Centers. I will inform Integrity Reginal Pain Center of providers associated with my

health care. **I am aware that if I have been found to have multiple prescribers for narcotics, the federal government recommends that Integrity Regional Pain Center report the violation of this agreement to the U.S. Department of Health and Human Services (HHS), the Office of the Inspector General (OIG), my insurance carrier and local law enforcement.**

D. **OTHER HEALTHCARE PROVIDERS**: I will inform all health care providers associated with my care that I receive pain management through Integrity Regional Pain Centers. I will maintain an unrestricted and current medical records release form on file with Integrity Regional Pain Centers and all other health care providers associated with my care.

E. **DRUG SCREENING**: I will participate in drug screening as a part of my treatment plan. I understand that random drug screenings will be conducted at the discretion of Integrity Regional Pain Center. Drug screenings include but are not limited to pill counts, urinalysis or blood tests. I agree to pay all costs associated with drug testing not covered by my insurance. Refusal or failure for any reason to submit to a drug screening at the time specified may result in termination of services provided by Integrity Regional Pain Center.

All new patients will receive a urine drug screen upon the first visit. All follow up patients will receive random urine drug screens or as requested by the provider. Any patient found to be in violation of the pain management agreement will no longer be able to receive narcotics from Integrity Regional Pain Center. **If no inconsistencies in the test results are received, then the patient will receive a full month's supply of medications at the 2 week follow up visit. However, if there are *any* inconsistencies in the test results at the follow up visit the patient will no longer be able to receive narcotics from Integrity Regional Pain Centers.**

F. **ILLEGAL AND NON-PRESCRIBED DRUG USE**: I understand that the use of any controlled medication not prescribed by Integrity Regional Pain Centers may result in termination of care. I authorize Integrity Regional Pain Centers to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, the DEA and the BNDD (Missouri Bureau of Narcotics and Dangerous Drugs) in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize Integrity Regional Pain Centers to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. I also understand that the use of any illegal substance may result in termination of care by Integrity Regional Pain Centers. **I am aware that if I have been found to have violated this agreement Integrity Regional Pain Center may need to follow the federal government recommendations and report the violation(s) to the U.S. Department of Health and Human Services (HHS), the Office of the Inspector General (OIG) my insurance carrier and local law enforcement.**

G. **LOST OR STOLEN MEDICAITONS**: I agree to safeguard all medications prescribed by Integrity Regional Pain Centers and understand that lost, stolen or damaged medications will not be replaced. Medications are an important part of your treatment regimen. We are concerned about your treatment and recognize that medications may be lost, stolen or damaged. However, our policy is that medications that are lost, stolen or damaged will not be refilled under any circumstances.
Per the federal government recommendations all reports of lost, stolen or damaged narcotics will be reported to the U.S. Dept of Health and Human Services (HHS); Office of the Inspector General (OIG); and local law enforcement.

If at any time a patient is arrested for selling medication or in possession of an illegal substance or drug paraphernalia, the patient will no longer be able to receive narcotics from any Integrity Regional Pain Centers.

H. **DRIVING & OPERATING EQUIPMENT**: Many pain medications can cause drowsiness and/or a very relaxed state of mind causing operation of equipment or vehicles to be dangerous. I agree to refrain from driving or operating dangerous equipment for 72 hours after any change in medication dosage and whenever I feel dizzy or drowsy. I will avoid driving or operating equipment until I know how I am affected.

I. **TERMINATION:** I will no longer be eligible for care at Integrity Regional Pain Center if I:

- Found to be in possession of illicit drugs or substances
- Trafficking in controlled or illegal substances
- Intoxicated or if arrested for DUI
- Alter my prescription in any way
- Sell or share my medications

Have you ever had any medical problems with alcoholism and/or drug abuse (including marijuana)?
Yes _____ No _____

If YES, did you receive in-patient or out-patient treatment? **Yes _____ No _____**
When did you receive this treatment? _________________________________
Are you currently still receiving treatment? **Yes _____ No _____**
If currently receiving treatment, pleas state name and phone number of your medical provider
____

Have you ever had any <u>legal problems</u> such as drug trafficking or manufacturing (including marijuana)?
Yes _____ No _____

Are/Have you been convicted, pleaded guilty, nolo contendere to any drug related charges?
Yes_____ No _____
Have you sentenced to imprisonment or probation? **Yes _____ No _____**
If yes, please explain: ____

Are you currently on probation? **Yes _____ No _____**
Do you have or use any other names that you use now are in the past (e.g., A.K. A.)?

Yes _____ No _____
If yes, please list:
____

Have you used any illegal drugs (including marijuana) within the past six months?
Yes _____ No _____
If YES, please explain:
____

____

Have you used any prescription drugs for which you did not have a personal prescription within the past six months? **Yes _____ No _____**
If YES, please explain:

____

____

Are you seeing any other medical providers? **Yes _____** **No _____**
If YES, please list:

____

Are you taking any controlled substances from other providers?
Yes _____ **No _____**

If YES, please list:

____

____

The following guidelines are a summary of current and new policies of the Pain Management Agreement.

IRPC Pain Patient Requirements:

1. All pain patients must have a signed narcotic agreement on file and follow the terms & conditions as described in the agreement.
2. All pain patients must give urine samples for drug screens at the initial visit, followed by random samples at any time during their follow up visits as requested by IRPC providers
3. A working phone number with available voicemail must be on file with IRPC. Voicemails must be checked by patient and calls returned to IRPC staff within a reasonable time frame.
4. Patient should have updated imaging within last 2 years
5. Patient must try other treatment options such as physical therapy and pain injections/procedures.
6. Patients who have been taking narcotics along with Benzodiazepine like Xanax or Valium, will need to choose one or the other. Both can no longer be taken together. Patients have 90 days to wean off Benzodiazepines or narcotics

IRPC Narcotic Termination Guidelines:

1. One negative urine drug screen (UDS) will result in a verbal warning.
2. Two consecutive negative UDS's will receive a written warning and prescribed narcotics will be decreased after each negative UDS.
3. Three consecutive negative UDS' will result in termination of narcotics agreement.
4. Written warning with first inconsistent UDS for other than prescribed narcotics or multiple providers.
5. Termination after second inconsistent UDS or multiple providers.
6. Any tampered or fake UDS sample will result in immediate termination.
7. Any presence of any illegal drug will result in immediate termination of the narcotics agreement.
8. Failure to appear for a Random Pill Count will result in immediate narcotics termination.
9. Failing a Random Pill Count will result in immediate narcotics termination.

IRPC will not make any exceptions for the following:

1. No narcotics for any pregnant women
2. No narcotics to anyone under 21 years of age.
3. No early replacement prescriptions for lost or stolen medicine
4. No early refills
5. No narcotics to anyone with a history of buying or selling illegal drugs.
6. No prescriptions of any Benzodiazepine or stimulants like Adderall.

All patients must follow the above rules & regulations at every visit. Any violations or abnormal behavior will result in termination of narcotics.

I UNDERSTAND AND AGREE TO THE CONDITIONS OF CARE DESCRIBED ABOVE AND WILL COMPLY WITH THEM. ALL OF MY QUESTIONS ABOUT THE TERMS OF THIS AGREEMENT HAVE BEEN ANSWERED TO MY SATISFACTION. FAILURE TO COMPLY WITH ANY OF THE TERMS OF THIS AGREEMENT MAY RESULT IN IMMEDIATE TERMINATION OF SERVICE. THIS AGREEMENT WILL REMAIN IN EFFECT AS LONG AS I AM A PATIENT OF ADVANCED PAIN CENTER.

______________________________ ______________________________

Patient Signature Date

______________________________ ______________________________

Physician Signature Date

I also acknowledge receiving a copy of the Opioid Analgesic REMS Patient Counseling Guide issued by the FDA and Opioid Safety and Naloxone Guide issued by MO Board of Pharmacy.

______________________________ ______________________________

Patient Signature Date

INTEGRITY REGIONAL PAIN CENTER

CONSENT AND AGREEMENT FOR CHRONIC CONTROLLED SUBSTANCE THERAPY

Integrity Regional Pain Center physician(s) are prescribing opioid medicine sometimes called narcotic analgesics to me for a diagnosis of ___________________________________. I agree to abide by and comply with the terms of this Agreement. I understand and agree that my failure to abide by and comply with every term of this Agreement constitutes grounds for Integrity Regional Pain Center to dismiss me as its patient and refuse to provide me further treatment.

This 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 risk associated with it, including but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete relief. The risks, benefits and side effects of medicines being prescribed to me have been discussed with me so that I understand those risks, benefits, and side effects.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids.

The other treatments discussed include:

____

____

I will tell my doctor about all other medicines and treatments that I am receiving, including controlled substances, psychotropic medications and pain management medications, prescribed, dispensed or otherwise authorized by other practitioners, within 24 hours of my receiving those other medicines or treatments.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly.

I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed.
Such activities include but are not limited to using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for him or herself.

I am aware that certain other medicines such as nalbuphine (Nubain), pentazocine, buprenorphine (Buprenex), and butorphanol (Stadol), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicine can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

I am aware and agree that multiple losses, thefts, or accidents that cause a physician of Integrity Regional Pain Center to issue me new prescriptions of controlled substances are grounds for Integrity Regional Pain Center dismissing me as its patient and refusing to provide me further treatment.

I understand and agree that false statements, misrepresentations, lies, forgery and failure to disclose important information relating to controlled substances and treatments involving controlled substances constitute Class D felonies (serious criminal violations) under Missouri statutes.

I understand and agree that controlled substances prescribed for me are for my use only and it is a felony (serious criminal violation) for me to transfer to or share my controlled substance medication with any other person.

I understand and agree that, pursuant to Missouri statute, controlled substance prescribed to me are open for inspection and copying by the Missouri Bureau of Narcotics and Dangerous Drugs and law enforcement in Missouri.

I understand and agree that Integrity Regional Pain Center may randomly perform drug tests to ensure that medications its providers are prescribing are in my body and to determine if unauthorized controlled substances are in my body. I agree to cooperate in such random drug tests. I understand that refusal to submit in a random drug test or failure of a random drug test constitutes grounds for Integrity Regional Pain Center to dismiss me as its patient and refuse to provide me further treatment.

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 development of addiction has been reported rarely in medical journals and is much more common with persons who have 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.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain however it has been seen and may occur to me. If it occurs increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

(Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

(Females only) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. Integrity Regional Pain Center Physicians do not and will not prescribe opioids to any pregnant patient. I am aware that should I carry a baby to delivery while taking these medicines the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

I have read and understand this consent form, or it has been read to me and I understood what was read to me.
I have had a chance to have all my questions regarding this treatment answered to my satisfaction. By signing this Agreement voluntarily, I agree to abide by the terms of this Agreement, and I give my consent for the treatment of my pain with opioid pain medicines.

Patient Signature ______________________________________ Date: ___________________________

Witness to above____

INTEGRITY REGIONAL PAIN CENTER

PATIENT ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

____
Patient Name

The above named and below signed patient (the "Patient") (guardian or legal representative) acknowledges that Integrity Regional Pain Center (the "Practice") has

_____________provided the Patient a copy of the Practice's Notice of Privacy Practices

_____________or the Patient has declined to receive a copy of such Notice of Privacy Practices.

The Notice of Privacy Practices was made readily available to the Patient.

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Signature of Patient

Date: ________________________

If guardian or legal representative; describe relationship here:

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INTEGRITY REGIONAL PAIN CENTER
PRIVACY PRACTICES NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY INTEGRITY REGIONAL PAIN CENTER (THE "PRACTICE") AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice please contact our Privacy Official who Ami Politte at P.O. Box 585, Desoto, MO 63020.

We are required by law to maintain the privacy of protected health information (as defined by law and referred to in this notice as "health information"), to provide you with notice of our legal duties and privacy practices and your rights with regard to health information and to make reasonable efforts to notify you if we believe a breach of our privacy practices has occurred that involves your health information. We are required to abide by the terms of this notice or any new notice we adopt (as described below).

We may use and disclose to others your protected health information without your consent for the following purposes. The Practice will not use your health information for marketing purposes or fundraising purposes and will not sell your health information.

Treatment: We may use and disclose your health information for purposes related to your treatment such as providing, coordinating or managing your health care and any related services. For instance, we may disclose your health information to other physicians that are involved in your treatment. We may disclose your health information to another physician or provider (e.g., a laboratory) who, at the request of your physician, becomes involved in your care by aiding with your diagnosis or treatment. Disclosures for treatment purposes include but are not limited to emergency circumstances.

Payment: Your health information may be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use and disclose your health information in support of our health care operations. For instance, we may disclose your health information as part of a quality assessment of our operations by us, by a health plan or other organization or by our employees or agents or as a part of review activities, licensing activities, and conducting or arranging for other business activities. Your name and the designation of the doctor you are visiting may also be visible to other patients when you sign in at our office. You may also be called by name in the waiting room.

Workers' Compensation: We may disclose your health information to workers' compensation insurers, workers' compensation administrative agencies or your employer if you are being treated for an injury arising from an injury that occurred on your job or a work related illness.

Business Associates: We may disclose your health information to persons or entities that provide services or goods related to your treatment or to our operations. For instance, a company that transcribes or copies our medical records will have access to your health information. We will have appropriate agreements with our business associates designed to protect further disclosure of your health information.

Legal Requirements: We may disclose your health information as required by law. As one example, we may disclose your health information if required to do so by a valid court order. In certain specific circumstances this may include the release of your health information to your employer. There are also limited circumstances under which the law requires us or permits us to disclose your health information such as required disclosure related to certain crimes, or permitted disclosure when we believe necessary to avert a serious threat to health or safety.

Appointment Reminders: Your name, the name of your physician and the existence of and time of your health care appointments may be disclosed to the person who answers your telephone (or left on an answering machine at your telephone number). An appointment reminder may also be sent to your address including your name, address, the name of our Practice, the name of your physician, the date and time of your appointment at the office of our Practice at which you have an appointment.

Others Involved in Your Care: When, in the professional opinion of your physician, we believe it to be in your best interest we may disclose your health information to your family member, your close friend or any person you identify who is involved in your medical care.

Research: We may use and disclose your health information to researchers only if the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Other: We may disclose your health information (i) to public health authorities for public health purposes such as preventing or controlling diseases; (ii) to a person who may have been exposed to a communicable disease or otherwise may be at risk of spreading a disease or condition; (iii) to public health agencies who oversee the health care system, government benefit programs and civil rights laws; (iv) to health oversight organizations for their lawful purposes; (v) to public health authorities and law enforcement for legally authorized purposes and legal enforcement relative to abuse and neglect related laws; (vi) to correctional institutions and law enforcement for the provision of health care to you (if you are an inmate) or the protection of or operations of correctional facilities; (vii) to the U.S. Food and Drug Administration or entities it may designate in furtherance of the purposes of the U.S. Food and Drug Administration; (viii) to coroners, funeral directors and organ donation organizations for their legally permitted purposes; (ix) to law enforcement for legally permitted action related to enforcement of criminal laws and prevention of certain criminal conduct; and (x) federal, state and local governmental agencies (including the Armed Forces in the case of a patient in the military) for their lawful purposes.

Authorized Uses: Uses or disclosures of your health information not covered by this Notice or the laws that apply to us may only be made with your written authorization delivered to the Practice's Privacy Official. For instance, if you request that we transfer your medical records to another provider we will ask you to sign an authorization for that transfer. You may revoke any authorization in writing, and we will no longer make disclosures authorized by your authorization. Disclosures made prior to the revocation in reliance on your authorization are not affected by the revocation.

Certain disclosures require your authorization. For instance, we will not use your health information for marketing purposes or any disclosures that constitute the sale of health information without your prior written approval. We will not contact you for fundraising purposes. When disclosing health information to determine your eligibility for insurance or other benefits (underwriting purposes), other than long term care insurance, we will not disclose genetic information about you.

Your Rights and How to Exercise Your Rights

You have the right to request us to restrict disclosure of your health information to a health plan (insurance company) for payment or health care operations so as to not disclose a health care item or service for which you have paid out of pocket in full. We must and will honor such written requests when signed by you, dated and delivered to our Privacy Official at the address below.

You have the right to request to inspect and receive a copy of your health information to be provided to you or a recipient you designate. Your request must be in writing, signed and dated, delivered to the Practice's Privacy Official at the address designated below and must clearly designate the name and address of the recipient. If the Practice maintains your health information in electronic format you may request an electronic copy of your health information in an electronic format you designate. If the format is not readily producible by the Practice, then the Practice must produce your health information in a readable electronic format that the Practice and you agree is acceptable. The health information you receive from the Practice may omit certain information as allowed by law. We may charge you a fee for providing you a copy of your health information. In most instances we must produce your copy of your health information within 30 days of receipt of your request. However, when your health information is stored off-site the time for us to produce your copy may be delayed up to 60 days. We must notify you when there will be a delay.

You have the right to request restrictions on certain uses and disclosures of your health information regarding your treatment, payment for services and health care operations. You may exercise that right by providing your request in writing delivered to the Practice's Privacy Official at the address designated below including your signature and the date of your signature. In many circumstances we are not required to agree to your request.

You have the right to request, and we must accommodate reasonable requests, from you that you receive communications of your health information from us by alternative means or at alternative locations. Again, your request must be in writing delivered to the Practice's Privacy Official at the address designated below including your signature and the date of your signature.

You have the right to request that we amend your health information. You may exercise this right through a written request delivered to the Practice's Privacy Official at the address designated below specifically stating the requested amendment and the reason for the amendment which request must include your signature and the date of your signature. In certain circumstances we may deny your request.

You have a right to request and obtain from us an accounting of certain disclosures of your health information made by us in the six (6) years preceding the date of your request. You may exercise this right through a written request delivered to the Practice's Privacy Official at the address designated below signed and dated by you. We are not allowed or required to account to you for certain types of disclosures of your health

information and, in certain circumstances, we are not allowed to or we may refuse to account to you for certain disclosures of your health information.

You have a right to obtain a paper copy of this Notice. Your request for a paper copy should be made to the receptionist at the Practice's office at which you visit your physician.

We will notify you in the event of unauthorized use or disclosure of your health information unless we demonstrate a low probability that your health information has been compromised.

If you believe your privacy rights have been violated, you may file a complaint with the Practice. You may file a complaint by sending a written statement explaining your complaint to the Practice's Privacy Official at the address designated below. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services. If requested in writing the Practice's Privacy Official will provide you the address. The Practice will not retaliate against you for filing a complaint.

Changes in Privacy Practices or This Notice

The Practice reserves the right to apply a change in its privacy practices to all health information in its possession prior to the effective date of any Notice describing such change. However, the Practice will promptly issue a new Notice of its Privacy Practices in place of this Notice. A copy of The Practice's current Privacy Practice Notice will be displayed in the waiting area of the Practice and on the Practice's web site. The Practice will provide you a written copy of its current Notice of Privacy Practices upon receipt from you of a written request signed by you and dated delivered to the Practice's Privacy Official at the address designated below.

Any request, notice or complaint regarding your health information that is to be delivered to the Practice's office should be addressed to the Practice's Privacy Official at the following address:

Integrity Regional Pain Center
Attn: Ami Politte
P.O. Box 585
DeSoto, MO 63020

The effective date of this notice is January 1, 2021.