Tri-State Pain Institute
1510 Wagon Wheel Lane
Fort Mohave, AZ 86426
Phone: 928-788-3333 Fax: 928-788-3555

Mailing Address: Tri-State Pain Institute
PO Box 10966
Fort Mohave, AZ
86427-0966

AUTHORIZATION TO RELEASE MEDICAL RECORDS

As required by the Health Information Portability and Accountability Act of 1996 and Arizona law, you have the right to request the opportunity to inspect and copy health information the pertains to you. We will evaluate your request and will either grant it or explain the reason why the request will not be granted. Your right to access does not extend to information complied in reasonable participation of, or for use in a civil, criminal, or administrative action or proceeding, or to information we received in confidence from someone other than a healthcare provider.

Patient's Name: ____

Date of Birth: _____________________ Social Security Number: ____

I request and authorize ____ to release health care information of the patient names above to:

TRI-STATE PAIN INSTITUTE

This request and authorization applies to:

- All health care information.
- Other: ____

  ____
- Healthcare information relating to the following treatment, condition, or dates: ___________________________

  ____

I understand and hereby also consent to the release of any and all alcohol and/ or drug abuse information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or psychiatric treatment records under the same condition outlined below. I understand that such information cannot be released without my specific consent.

I understand that I have the right to revoke this authorization at any time. I understand that I have the right to revoke this authorization, I must do so in writing and present my written revocation to the medical records department, and I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the rights to consent a claim under my policy.

Patient Name: ____ Date: ________________________________

PATIENT INTAKE WORKSHEET

Patient Name: ____ DOB: ______________________________

Current Address: ____

City: ___________________________ State: ___________________ Zip: ___________________

Current Phone #s: Home: ___________________ Cell: _________________ Work: __________________________

E-Mail Address: ____

Social Security Number (Patient): ____

Employer: ____

Insured (Policyholder) Name: ____

Social Security Number (Insured & Responsible Party): ____

Emergency Contact: _______________________________________ Relationship: ____________________________

Home #: ___________________ Cell #: _____________________ Work #: ___________________________

WORKER'S COMPENSATION INSURANCE

W/C Carrier: ____

Policy Number: _____________________ Group Number: ________________ Effective Date: __________________

Insurance Name: ____

Date of Injury: __________________ Body Parts Injured: ____

Attorney: ______________________________________ Phone Number: ____________________________________

PERSONAL INJURY INFORMATION

Attorney: ______________________________________ Phone Number: ____________________________________

Office Contact: _________________________________ Date of Injury: ____________________________________

TRI-STATE MEDICAL SPECIALISTS, LLC
1510 E. Wheel Lane, SE. 110
FM Mohave, AZ 86426
PH: 928-788-3333 FAX: 928-788-3555

NOTICE OF PRIVACY POLICY FOR PROTECTED HEALTH INFORMATION (PHI)

The office of Tri-State Medical Specialists, LLC is dedicated to protect your "nonpublic personal health information". This notice is to tell you how and why we collect that information, and who has access to that information.

HOW WE COLLECT YOUR INFORMATION
Your personal demographic information such as name, address, birth date, social security number, and medical insurance information is obtained from you. This is why we ask you to fill out the patient information sheet and why we ask for a copy of your insurance card. This ensures that the information we collect is correct.

If you came to our practice through a hospital encounter, we may obtain the information from the hospital. However, on your first visit to this office, we will ask you to fill out our information sheet to ensure that the information we received from the hospital was correct.

We may also ask a doctor or other health care provider who referred you to this practice to give us health information that will enable us to better treat your medical condition. This benefits you in that we will have test results that have already been obtained by the referring entity.

WHY WE COLLECT THIS INFORMATION
We collect this information so that we can treat your medical condition and obtain payment from your health insurance.

MAINTAINING ACCURATE AND TIMELY INFORMATION
To ensure that the information we maintain is accurate, each time you visit the office you will be responsible to update your information.

WHO HAS ACCESS TO THIS INFORMATION
Any person or persons you designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process health care claims and obtain payment for our services have access to you Protected Health Information.

Entities such as Governmental Oversight agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your Protected Health Information. These entities are mandated by law and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION
We release your information only to those people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entities that need this information for claims processing have access to your Protected Healthcare Information.

YOUR RIGHTS
You have the right to inspect your Personal Healthcare Information. You also have the right to amend any errors you may find in your records.

If you leave this practice, your Protected Healthcare Information will continue to receive the protection outlined in this notice.

COMPLAINT/COMMENTS
If you have any complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Services, at 200 Independence Avenue SW, Room 509F, HHH Building, Washington D.C. 20201. You also may contact the Privacy Officer of this practice at P.O. Box 10966. Fort Mohave, AZ 86427-0966.

This notice is effective as of November 1, 2014

Received and Read: ______________________________ Date: ____________________

MY PROVIDERS

My primary care provider is: ____

I also see or have seen as consultants / specialists

Cardiologist: ___________________________________ Neurologist: _____________________________

Neurosurgeon /Spine Surgeon: ____

Orthopedic Surgeon: ________________________Prior Pain Doctor: _______________________________

Pulmonologist: _____________________________ Rheumatologist: _______________________________

Oncologist: ________________________________ Podiatrist: ____________________________________

Other: ____

I have had Radiology and Imaging at:

______WARMC ______VVMC ______KRMC ______HRMC ______CRMC

______Mt. West ______LHC Imaging ______Coast MRI OTHER ________________________

Electrodiagnostics ("Nerve Test")? ______NO ______ YES By Whom: ________________________

Sleep Study? ______ NO ______YES By Whom: ____

Recent Cardiac Evaluation? ______NO ______YES By Whom: ______________________________

When: ____________ What Was Done: ______ EKG _______Echo _______ Stress Test

Chiropractic or Physical Therapy: ______ NO ______YES When: ____________________________

Where: ____

When was the last time you were hospitalized? ________________ Where: ____________________

Reason:

PAIN HISTORY

TRAUMA (Most recent first):

When? _________________ What was injured? _______________________________________

Treatment: ____

*Additional Prior Trauma (Please explain what happened, what was injured, and how you were treated):

WORK COMP INJURY (Most recent first):

When? ___________________ What was injured? _____________________________________

Treatment: ____

Settlement: ____

*Prior W/C History (Please explain what happened, what was injured, and how you were treated):

PAIN RELATED INTERVENTIONS / OPERATIONS (CIRCLE PLEASE):

HEAD: Trigeminal Injection/Surgery Occipital Nerve Block TMJ Injection Suboccipital Stimulator

Other: ____

NECK: Epidural Facet Injections Trigger Point Injections Radiofrequency ("Nerve Burn")

Stimulator Surgery: (Front / Back / Both) Other: ___________________________________

THORACIC: Epidural Facet injections Trigger Point Injections Radiofrequency ("Nerve Burn")

Stimulator Surgery: (Front / Back / Both) Other: ______________________________

BACK: Epidural Facet injections Trigger Point Injections Radiofrequency ("Nerve Burn")

Stimulator Surgery: (Front / Back / Both) Drug Pump Other: ______________________

JOINT: A = Arthroscopy R = Replacement

Injections: Shoulder Elbow Wrist/Hand Hip Knee Steroid / Collagen Ankle

Surgery: Shoulder (A / R) Elbow (A / R) Wrist/Hand (A / R) Hip (A / R)

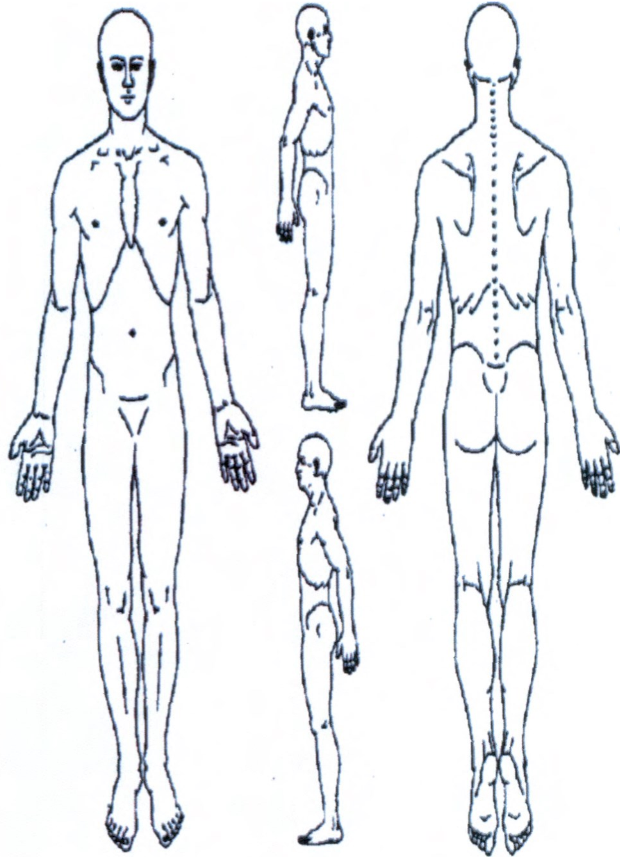
Knee (A / R) Ankle (A / R)

OTHER:

Pain Diagram

Please mark the area of injury or discomfort on the chart below using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
-------------	oooooooo	^^^^^	XXXXXX	●●●●●
------------	oooooooo	^^^^^	XXXXXX	●●●●●



Daily Pain Score

PLEASE RATE THE FOLLOWING ON A SCALE OF O - 10

0 = NO PAIN

1-4 = LOW AMOUNTS OF PAIN

5-7 = MODERATE PAIN

8-10 = SEVERE PAIN

Average__________

Best_____________

Worse____________

Things that make my pain worse:

Things that make my pain better:

I CURRENTLY TAKE THE FOLLOWING FOR PAIN AND RELATED COMPLAINTS (Please Circle):

Tylenol /Codeine	MS Contin	Suboxone	Naprosyn	Flexeril	Gabapentin
Hydrocodone	Dilaudid	Subutrex	Mobic	Soma	Cymbalta
Zohydro	Methadone	Fentanyl Patch	Celebrex	Valium	Lyrica
Oxycodone	Opana	Butrans Patch	Diclofenac	Zanaflex	Tegretol
OcyContin	Opana ER	Tramadol	Indomethacin	Xanax	Dilantin
Morphine	Kadian	Motrin (Ibu)	Advil /Aleve	Ativan	Topical Cream

Other:

MY MEDICAL HISTORY

PLEASE CIRCLE ALL THAT:

CVS Hypertension Cholesterol MI Aneurysm Heart Failure PAD Carotid Disease
LE Edema Pacemaker On Blood Thinners Chest Pain Palpitations

LUNGS COPD Asthma Pneumonia Valley Fever Asbestos Bronchitis Shortness of Breath

GI GERD/PUD Irritable Bowel Crohn's Dz Gallbladder Diverticular Dz Constipation
Hemorrhoids Pancreatitis Bowel Obstruction Liver Dz: (Hepatitis / Cirrhosis)

GU/ Renal UTI Kidney Stones Renal: (Dialysis? Y N) Bladder Disease
Males: Prostrate Hypertrophy (BPH) Erectile Dysfunction ***Females:*** Stress Incontinence

ENDO Diabetes: (Insulin / Meds) Osteoporosis Thyroid: (Hypo / Hyper) Low T

NEURO Stroke Seizures Tremor (Essential / Parkinson's) HA/Migraine MS Dementia
Hydrocephalus (Shunt?) Neuropathy ALS RSD/CRPS Restless Leg Syndrome

GYN Periods: (Reg. / Irreg.) Post-Menopause Menopause Pre-Menopause Hysterectomy

CANCER Skin (Melanoma) Lung H/N Stomach/ Intestine/ Colon Blood Lymphoma Brain
Prostrate Ovarian Uterine Bone Kidney Bladder Thyroid
Other:______________ In Treatment _____ In Remission _____ Metastatic Disease _____

RHEUM Arthritis (Osteo / Rheum) Lupus Fibromyalgia Raynaud's

PSYCH Depression Anxiety Bipolar Schizophrenia PTSD Decreased Libido

HEME Anemia Platelets (Low / High) "Bleeder" Hemochromatosis

INFEC +HIV MRSA Chronic Infection (Where? _____________)

SENSORY Glasses (Reading Only) Cataracts Glaucoma Hearing Loss Ringing in Ears Legally Blind
Double Vision Loss of Smell

OTHER:

MY MEDICATIONS, ALLERGIES AND FAMILY HISTORY

LIST ALL NON-PAIN RELATED MEDICATIONS: ______ NONE _______ SEE ATTACHED LIST

BLOOD THINNERS (circle): Aspirin (81mg 325mg) Plavix Coumadin Xeralto Other:

OTHER MEDICATIONS (Name, Dose, and how often you take the medication):

I AM ALLERGIC TO: ________ NONE

IODINE RELATED (circle): Shellfish IV Contrast Contrast with Pain Injection

MEDICATION ALLERGIES (List Medication and Reaction):

PLEASE LIST ALL DISEASES THAT RUN IN YOUR FAMILY: _________ I AM ADOPTED

MY SURGICAL HISTORY

PLEASE CIRCLE ALL THAT APPLY { If multiple, please write how many on the line }

SPINE: Cervical - Front (ACDF) _____ Back (Laminectomy) _____ Both_____ Fusion Y N

Thoracic - Laminectomy _____ Fusion _____ Scoliosis Surgery _____ Vertebroplasty _____

Lumbar - Laminectomy _____ (Back / Front / Side) Vertebroplasty _____

Stimulator (Spinal / Peripheral) Syrinx Drainage Drug Pump SI Fusion

ORTHO: {A = Arthroscopy R = Replacement}

Right

Shoulder A _____ R _____ Elbow A _____ R _____ Wrist/Hand A _____ R _____

Hip A _____ R _____ Knee A _____ R _____ Ankle/Foot A _____ R _____

Carpal Tunnel ______ Ulnar Nerve Release _____ Fracture Surgery _____

Left

Shoulder A _____ R _____ Elbow A _____ R _____ Wrist/Hand A _____ R _____

Hip A _____ R _____ Knee A _____ R _____ Ankle/Foot A _____ R _____

Carpal Tunnel ______ Ulnar Nerve Release _____ Fracture Surgery _____

HEAD: Craniotomy (Tumor / Aneurysm / Trauma) Aneurysm Coiling Shunt (VP / LP) DBS Pituitary

EYES: Cataracts Glaucoma Surgery Detached Retina Lasik / Vision Surgery

ENT: Thyroid Sinus Surgery Head / Neck Tumor Ear Surgery Vocal Cord Surgery

LUNG: Bronchoscopy Lung Biopsy Lung Resection Drainage of Lung Fluid

CV: Heart Stent _____ Coronary Bypass Surgery _____ Cardiac Ablation _____ Pacemaker

Carotid (Stent / Endarterectomy) LE Stent Aortic Stent Renal Stent Femoral Stent

ABD: Appendectomy Gall Bladder Colon Resection Esophagus Stomach / PUD Trauma

Abdominal Surgery (Trauma / Tumor / Infection / Adhesions) Hemorrhoid Pancreas Surgery

Endoscopy (Upper / Lower) Liver (Biopsy / Resection) Drainage of Fluid Colostomy

GYN: Hysterectomy Tubal Ligation Endometriosis Adhesions C-Section D&C

CANCER: Skin Lung Stomach/ Intestine/ Colon Brain Breast (Biopsy / Mastectomy) Prostate Ovarian

Ovarian Uterine Bone Kidney Bladder Thyroid Head / Neck

GU: BPH Penile Prosthesis Bladder Suspension Uterine Suspension Renal

OTHER SURGERIES:

SOCIAL HISTORY

Circle and Answer All That Apply:

Are You A Snowbird? Y N If so, what is your permanent address?

Marital: Single Married Divorced Separated Co-Habitation Partner

Vocational: Work (F/T or P/T) Unemployed Retired Disabled Not Working by Choice

Children: Biological ____ Ages? Adopted / Stepchildren _____ Ages?

Disability: N/A Applying Receiving Benefits S/S W/C

Abuse: Spousal Physical Verbal Emotional PTS Syndrome

Transportation: Own Auto / Motorcycle Get a Ride Public Transportation /Taxi Other:

Tobacco: **Cigarettes** Age Started? _____ Age / Year Quit? _____ PPD? _____

Pipe Age Started? _____ Age / Year Quit? _____

Cigar Age Started? _____ Age / Year Quit? _____

Alcohol: Beer Wine Spirits How much and how often? ____________________________

Are you an alcoholic? Y N DUI? Y N

Drugs: Rx Meds MJ (Certified? Y N) Meth Cocaine Heroin Other? __________

Arrest Record for Drugs? Y N Attended Rehab? Y N

12 Step Program (AA or NA)? Currently _______ In The Past ________

ANYTHING ELSE YOU WOULD LIKE TO ADD?

TRISTATE PAIN INSTITUTE

Welcome to our clinic! We want to make your visit with us as efficient and productive as possible. To do so, it is important that we obtain as much information before you see one of our providers. To help us help you, please do the following:

- Please provide us your current drivers license or other photo ID, a copy of your insurance card, pharmacy card and any other related information.
- If you have x-ray films or a CD, please give them to the medical assistant when called back. If you have had any additional relevant x-rays or imaging within the last 2 years, please inform our staff to obtain reports. A consent form will need to be signed.
- If you were referred from a doctor's office, please inform our staff who that is. We would like to try and obtain a copy of your most recent records. A consent form will need to be signed.
- If you have recently been seen in another pain clinic, please inform our staff who that was. We would like to try and obtain a copy of your most recent records and a discharge letter. A consent form will need to be signed.
- Please identify any consultant or specialist you have seen recently. We would like to try and obtain a copy of your most recent records. A consent form will need to be signed.
- Take your time and fill out this form completely. This will allow us to efficiently enter this information into our electronic medical record, and allow you to be seen sooner.
- You are entitled to a copy of today's consultation... just ask.

Any constructive feedback you provide us will be welcomed. Our staff and providers are committed to helping you back to the best health you can achieve.

-The Staff and Providers of TriState Pain Institute

TriState Pain Institute

CONTROLLED SUBSTANCE CONTRACT

This agreement reflects my use of controlled substances for chronic pain prescribed by TriState Pain Institute. I have been informed and understand the policies regarding the use of controlled substances by TriState Pain Institute, it's providers, and staff. I acknowledge that I will be provided controlled substances while participating as a patient in this practice only if I adhere to the following conditions:

1. I will use the substances only as directed by the TriState Pain Institute staff.
2. I will not receive replacement medications for any medications of which I have lost or have been stolen.
3. I will receive controlled substances only from the providers in this office.
4. I will not expect to receive additional medication prior to the time of my next scheduled refill, even if my prescription runs out.
5. I will not consume excessive amounts of alcohol in conjunction with controlled substances.
6. I agree to schedule and keep scheduled follow-up appointments at recommended intervals. I understand that failure to keep appointments may lead to discontinuation of treatment.
7. If it appears to the physician that there are no significant benefits to my daily activities or any improvement in my quality of life from the controlled substance, I will gradually reduce my medication as directed.
8. I agree to partake in urine and blood screens to detect the use of non-prescribed medications (including "street drugs") at any time.
9. I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy and behavioral medicine strategies. I also recognize that my active involvement in the management of my pain is extremely important. I agree to actively participate in all aspects of my Pain Management Program to maximize functioning and improve coping with my condition.
10. I am responsible for keeping track of the amount of medication left and to plan ahead for arranging the refill of my prescriptions in a timely manner so I will not run out of medications.
11. I agree to partake in a pill count at any time, to document the amount of my remaining medications.
12. I will participate in the monthly prescription program. **
13. If I violate any of the above conditions, my obtaining prescriptions and/or treatment recommended and agreed upon, I may be terminated as a patient from this practice.
14. If the violation involves obtaining controlled substances or any prescription for my pain condition from another individual or if I engage in any illegal activity such as altering a prescription, I understand that the incident may be reported by this office to other physicians caring for me, local medical facilities, pharmacies and other authorities such as the local police department, Drug Enforcement Agency, etc. as deemed appropriate for the situation.

MEDICATION REFILL INFORMATION

A. Advance notice of 2-3 business days is required for refills of non-controlled prescriptions.
B. Requests for scheduled refills must be telephoned only during regular office hours Monday-Friday (9AM-5PM)). Refills will not be made at night, on holidays, Fridays or on weekends.
C. Most controlled substances cannot (Class II) be telephoned into a pharmacy. You must make arrangements to pick up your prescription during regular business hours.

****MONTHLY PRESCRIPTION PROGRAM**

A. I will be given a monthly prescription of all controlled substances (Class II), unless otherwise specified. Depending on pharmacy, drug plan or pharmacy coverage, this generally ranges from 28 to 30 days.

CONTROLLED SUBSTANCE CONTRACT (PT 2)

GLOBAL PAIN INTERVENTION AND MANAGEMENT CONTRACT

This agreement covers my participation in pain procedures or other interventions outside of the TriState Pain Institute. I acknowledge that agree the following: (1) to only use prescribed pain medications (including opioids) as outlined by the pain contract as documented above; (2) to complete all diagnostic studies and other testing in a timely manner once authorized (finances permitting), in order to arrive at a diagnosis; (3) to submit for urine drug toxicology when requested and (4) should you be admitted to any emergency room hospital, and agree to bring all discharge, lab, and x-ray or imaging reports to your next appointment. In addition any negative comments or allegations against the TriState Pain Institute, its providers and/or staff, must be immediately reported, especially if the source is any hospital administrator, staff or provider.

EXCEPTIONS ARE AS FOLLOWS:

- Intramuscular steroid injections received at you primary provider, specialist, or urgent care / emergency room.
- Joint injections performed by your primary provider, orthopedic or rheumatology consultant, or within the setting of urgent care or emergency room.
- Botox or steroid injections for headaches, performed by a neurologist.
- Any image directed procedure performed by a radiologist, but only if you are admitted to the hospital.
- Any injection following notification and permission given by a TriState Pain Institute provider.

It is important that all spine interventional (injection) management, be performed at the TriState Pain Institute or by its providers. We are responsible for your total pain management, and rarely are we informed when these injections/blocks are scheduled or receive any documentation of this. Furthermore many of these injections outside of the TriState Pain Institute are properly authorized, and you may be financially responsible to these other providers.

VALIDATION OF CORRECT MEDICATION MANAGEMENT

We are required by statute to regularly and randomly as needed, drug test all patients. There are no exceptions. Urine screening is the most common source of specimen, but also blood can be used. The TriState Pain Institute reserves the right to observe you while the specimen is obtained. Tampering, substituting or tampering with the specimen in a deceptive manner constitutes grounds for termination. Should you be unable to provide a specimen when requested, you are responsible to return no later that 24-48 hours (72 hours over a weekend) to do so.

THIS AGREEMENT WILL SUPERSEDE ALL OTHER AGREEMENTS.

BY SIGNING BELOW, I INDICATE THAT I UNDERSTAND AND AGREE TO ALL THE TERMS OF THE ABOVE CONTRACT. I HAVE ALSO RECEIVED A COPY OF THIS FOR MY RECORDS.

_______________________________________ Patient

_______________________________________ Date

_______________________________________ Witness

_______________________________________ Date

TriState Pain Institute

INFORMED CONSENT

TREATMENT FOR NON-CANCER / CANCER PAIN

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician/health care provider complies with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician–patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

I have agreed to use opioids (morphine-like drugs) as part of my treatment for chronic pain. I understand that these drugs can be very useful, but have a high potential for misuse and are therefore closely controlled by the local, state, and federal government. Because my physician/ health care provider is prescribing such medication to help manage my pain, I agree to the following conditions:

1. I am responsible for my pain medications. I agree to take the medication only as prescribed.
   a. I understand that increasing my dose without the close supervision of my physician could lead to drug overdose causing severe sedation, respiratory depression, and death.
   b. I understand that decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal. **Withdrawal symptoms** can include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh", abdominal cramps, and diarrhea. These symptoms can occur 24-48 hours after the last dose and can last up to 3 weeks.

2. **I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician/health care provider at TriState Pain Institute.**

3. There are side effects with opioid therapy, which may include, but not exclusively; skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental health) and/or motor ability. Overuse of opioids can cause decreased respiration.

It is my responsibility to notify my physician/health care provider of any side effects that continue or are severe (i.e., sedation, confusion). I am also responsible for notifying my pain physician immediately if I need to visit another physician or need to visit an emergency room due to pain, **or if I become pregnant**.

4. I understand that the opioid medication is strictly for my own use. The opioid should **never** be given or sold to others because it may endanger that person's health and is **against the law.**

5. I should inform my physician of all the medications that I am taking, including, herbal remedies. Medications like Valium or Ativan; sedatives such as Soma, Xanax, Fiorinal; antihistamines like Benadryl. As well as alcohol and cough syrup containing alcohol and codeine can interact with opioids and produce serious side effects.

6. I understand that opioid prescriptions will not be mailed. If I am unable to obtain my prescriptions monthly, I will be responsible for discussing this with my pain physician in advance.

7. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of

prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.

8. I will communicate fully with my physician to the best of my ability at the initial and all follow-up visits. This includes my pain level and functional activity along with any side effects of the medications. This information allows my physician to adjust my treatment plan accordingly.

9. You should not use any illicit substances, such as cocaine, marijuana, ect. while taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship.

10. The use of alcohol together with opioid medications is contraindicated.

11. I am responsible for my opioid prescriptions. I understand that:

- **a.** Refill prescriptions can be written for a maximum of one-month supply.
- **b.** It is my responsibility to schedule appointments for the next opioid refill before I leave the clinic or within 3 business days of the last clinic visit.
- **c.** I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
- **d.** If my medication is stolen, I will report this to my local police department and obtain a stolen item report. I will then report the stolen medication to my physician. If any medications are lost, misplaced, or stolen, my physician may choose not to replace the medications or to taper and discontinue the medications.
- **e.** Refills will not be made as an "emergency", such as on Friday afternoon because I suddenly realized I will "run out tomorrow".
- **f.** Prescriptions for pain medicine or any other prescriptions will be done only during an office visit or during regular office hours. No refills of any medications will be done during the evening or on weekends.
- **g.** You must bring all opioid medications and adjunctive medications prescribed by your physician or health care provider in the original containers/bottles at every visit.
- **h.** Prescriptions will not be written in advance due to vacations, meetings, or other commitments.
- **i.** If an appointment for a prescription refill is missed, another appointment will be made as soon as possible. Immediate or emergency appointments will not be automatically granted.
- **j.** Generally, no "walk-in" appointments for opioid refills will be granted, however exceptions can be made depending on circumstances.

12. While physical dependence is to be expected after long-term use of opioids, **signs of addiction, abuse, or misuse shall prompt the need for substance dependence treatments as well as weaning and detoxification from the opioids.**

- **a. Physical dependence** is common to many drugs such as blood pressure medications, anti-seizure medications, and opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal response. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.
- **b. Addiction** is a primary, chronic neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm,

and cravings. This means the drug decreases one's quality of life. If the patient exhibits such behavior, the drug will be tapered and such a patient is not a candidate for an opioid trial. He/she will be referred to an addiction medicine specialist.

c. **Tolerance** means a state of adaptation in which exposure to the drug induces changes that result in a lessening of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a *realistic* decrease of the patient's pain.

13. If it appears to the physician/health care provider that there is no improvement in my daily function or quality of life from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed by the physician.

14. If I have a history of alcohol or drug misuse/addiction I must notify the physician of such history since the treatment with opioids for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery **is a necessity**.

15. I will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment, and sometimes two to three days extra if the prescription ends on a weekend on holiday. This extra medication is not to be used without the explicit permission of the prescribing physician unless an emergency requires your appointment to be deferred one or two days.

16. I agree and understand that my physician reserves the right to perform random or unannounced urine drug testing. If requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my doctor may change my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the doctor/patient relationship. Urine drug testing is not forensic testing, but is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.

17. I agree to allow my physician/health care provider to contact any health care professional, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions *if the physician feels it is necessary.*

18. I agree to a family conference or a conference with a close friend or significant other *if the physician feels it is necessary.*

19. I understand that non-compliance with the above conditions may result in a re-evaluation of my treatment plan and discontinuation of opioid therapy. I may be gradually taken off these medications, or even discharged from the clinic.

I have read the above information or it has been read to me and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy and acknowledge receipt of this document.

Patient's Signature ___________________________________ Date ________________________________

Witness's Signature __________________________________ Date ________________________________

Tri-State Pain Institute
1510 E. Wagon Wheel Lane, Ste. 110
Fort Mohave, AZ 86426
PH: 928-788-3333   Fax: 928-788-3555

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I have been presented with a copy of the **Notice of Privacy Practices**, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Print Patient Name: ____________________________________ Date: ______________________

Relationship (if not signed by patient): ____

Please name all of your family/friends we can contact and/or discuss your medical information with:

Name: _______________________ Relationship: __________________ Phone: _______________

Name: _______________________ Relationship: __________________ Phone: _______________

Name: _______________________ Relationship: __________________ Phone: _______________

Name: _______________________ Relationship: __________________ Phone: _______________

I wish to place the following restrictions on disclosure of my health information:

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Signature: ____ Date: ________________

CONSENT TO TREAT and Authorization to Release Information

I consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the attending physician. I authorize TriState Medical Specialists, LLC to furnish my Insurance carriers information regarding history, physical findings and treatment rendered as allowed by HIPAA. I further authorize any holder of medical or other Information about me to release such information to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare / other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment or medical insurance benefits to the party who accepts assignment.

Authorization to Pay Benefits to Provider

I request and authorize that payments for authorized Medicare/other insurance company benefits be made directly to TriState Medical institute, LLC on my behalf for any services furnished to me by TriState Medical Specialists, LLC, who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I also understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 11288 of the Social Security Act and 31 USC. 3801-3812 provides penalties for withholding this Information).

Patient Responsibility

I agree that I am responsible for all charges incurred in this office, if my insurance coverage does not provide full benefits. I will pay any patient responsibility balance due within 30 days unless I have made other arrangements with TriState Medical Specialists, LLC. Further, I agree that this visit is not related to a litigation matter as it is my understanding that TriState Medical Specialists, LLC does not see this type of case for evaluations and treatments. If cancellation of my appointment becomes necessary, I will contact Tri-State Medical Institute, LLC no later than twenty-four (24) hours prior to my scheduled appointment time. I understand that failure to follow the cancellation of appointment policy, I may be subject to a charge of fifty dollars ($50.00) and such charge is not payable through my insurance. I have read the TriState Medical Specialists, LLC Office Policy Statement and all my financial questions were answered.

Ancillary Services

As a convenience to our patients, TriState Medical Specialists, LLC offers direct dispensing of medications, topical creams, durable medical equipment, as well as on site diagnostic testing as recommended. I understand I am under no obligation to obtain these pharmaceuticals, orthotics, or services through TriState Medical Specialists, LLC, and at any time can request a referral to an independent pharmacy, medical supply outlet, imaging center, hospital or another provider.

Assignment of Insurance Benefits

I hereby authorize direct payment of all medical/surgical benefits to TriState Medical Specialists, LLC (dba TriState Medical Institute), for services rendered to them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance. I also authorize my doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Authorization to Release Information

I hereby authorize TriState Medical Specialists, LLC (dba TriState Medical institute) to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

Patient Name: ________________________________ **Parent/ Guardian**:________________________

Signature: ____ **Date:** ______________________________

TRISTATE PAIN INSTITUTE

Policy for Financial Responsibility

Dear Valued Patient,

Your providers at the TriState Pain Institute often recommend services, orthotics, non-opioid pain medications, and/or topical cream agents or interventions as part of your overall plan of care. Our goal is to provide effective pain management (and overall good health), while minimizing the risk of medication side effects and addiction. While you are under no obligation to accept any or all of our suggestions, we hope they are at least considered.

A struggling economy has placed all of us under considerable fiscal pressure. Furthermore, specific plan coverage and formulary benefits (the part of your insurance responsible for your medications) often vary from patient to patient. We believe, however, your healthcare transcends the ups and downs of both our local and national financial conditions. In light of this, we will attempt to determine what is covered by your insurance plan and formulary, in addition to any monetary responsibility you may have. You are however under no obligation to follow these recommendations. Furthermore, you are free to choose to obtain any or all services, through local pharmacies or mail order drug services, DME retailers, hospitals, or other providers.

Ideally monetary or transportation challenges should not limit treatment. If it is more convenient to obtain medications or other clinical services at our clinic (if possible), we will attempt to coordinate your office visits with additional care.

Thank you for choosing the TriState Pain Institute as one of your healthcare providers. As with all of our services, please bring all questions or concerns to our attention immediately. As always, we strive each day to earn your confidence as your partner for good health.

Thank you for your consideration,

Providers and Staff
TriState Pain Institute

I have read and understand all of the above.

______________________________________ ________________________________

PATIENT DATE