PPW Health/Pro Spine & Pain

New Patient Intake Form

Information

Full Name: ______________________________ Date: ____________
Last *First* *M.I.*

Height:__________ Weight:__________ Is there any chance of Pregnancy? YES ☐ NO ☐

Referring Provider: ______________________________
Name *Phone*

Primary Care Physician: ______________________________
Name *Phone*

Cell Phone: ____________________ Email:____________________

Do we have permission to text you? YES ☐ NO ☐

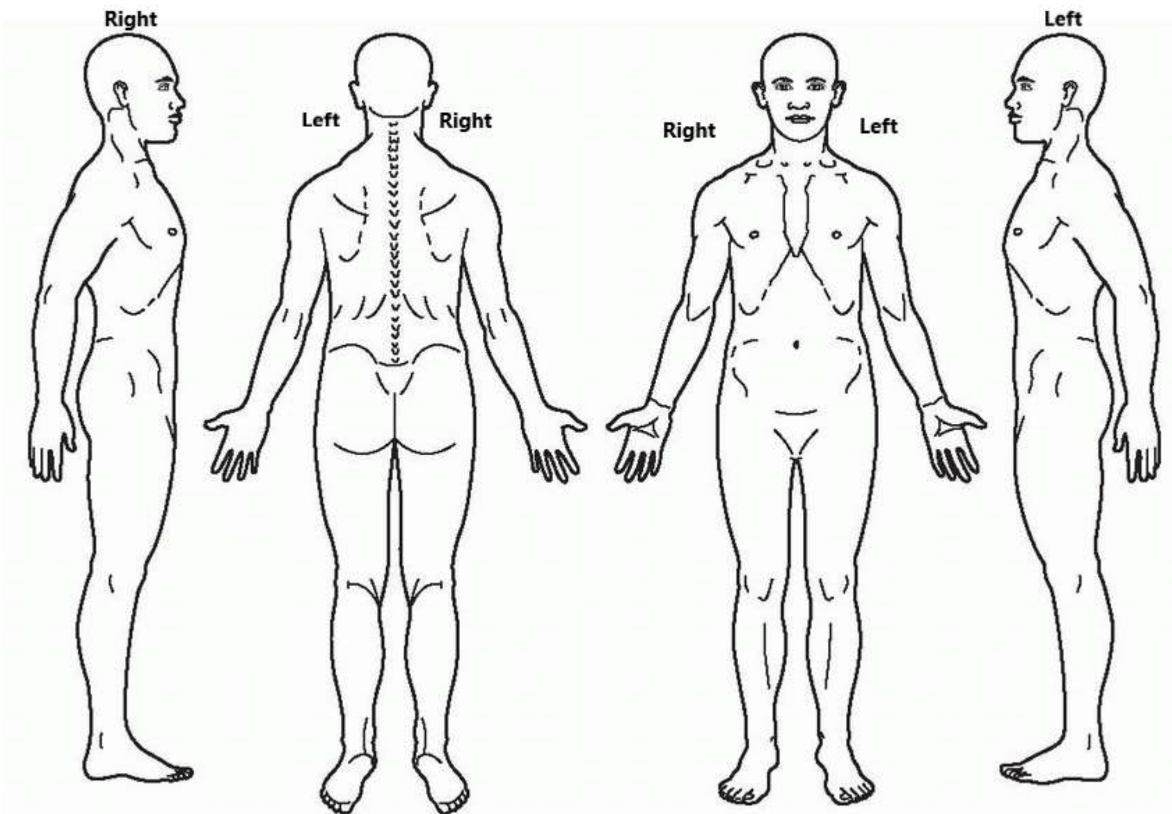
How did you hear about us? ______________________________

Pain Location and Information

Cause of pain: Work Injury ☐ Auto Accident ☐ Fall/Injury ☐ Other ☐ Explain: ____________________

Where is your pain located? ______________________________

Please color all areas of pain below



Workers Compensation Claim

Please complete information below if this pain is related to a W/C injury

Workers Comp Company:					
Adjuster Name:		Adjustor Phone Number:			
Adjustor Fax Number:		Claim Number:			
Date of Injury:		State of Injury:		Body parts Covered:	

Please describe the injury: ____

Motor Vehicle Accident

Please complete the information below if this pain is related to a MVA injury

Were you the driver?	☐Yes ☐No	Were you the passenger?	☐Yes ☐No	Were you wearing a seatbelt?	☐Yes ☐No
Did you lose consciousness?	☐Yes ☐No	How long?		Were there other occupants in the car?	☐Yes ☐No
What type of vehicle were you driving?	☐Car ☐Truck ☐Van ☐Motorcycle ☐ Other:				

Please describe the accident: ____

Describe your pain: ☐ Achy ☐ Burning ☐ Constant ☐ Discomfort ☐ Dull ☐ Gnawing ☐ Heavy ☐ Intermittent ☐ Localized ☐ Numb ☐ Pressure ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Tingling ☐ Throbbing Other:____________________

Is your pain: ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

When did your pain begin? ____________________

Where does your pain radiate? ____________________

What aggravates your pain? ☐ Ascending stairs ☐ Bending forward ☐ Bending backwards ☐ Changing positions ☐ Coughing ☐ Defecating ☐ Descending stairs ☐ Driving ☐ Exercise ☐ Jumping ☐ Laying down ☐ Lifting ☐ Sitting ☐ Sneezing ☐ Standing ☐ Twisting ☐ Walking ☐ Daily activity ☐ Movement ☐ House chores ☐ Weather Other: ____________________

What improves your pain? ☐ Exercise ☐ Heat ☐ Ice ☐ Lying Down ☐ Massage ☐ Opioid medication ☐ OTC medications ☐ Physical therapy ☐ Rest ☐ Stretching ☐ Walking ☐ Elevation ☐ Changing positions ☐ Sitting ☐ Hot bath/shower ☐ TENS unit

Other: ____________________

What previous treatment have you tried?

☐ Chiropractic When?____
☐ Physical therapy When?____
☐ Epidural Injections When?____
☐ Medial branch blocks When?____
☐ TENS unit When?____
☐ Home exercise program When?____
☐ Nerve Block When?____
☐ Acupuncture When?____
☐ Spinal cord stimulator When?____
☐ Intrathecal pain pump When?____
Other: ____________________

Opioid Medications	Did it help?	Non-Opioid Medications	Did it help?
☐ Hydrocodone	Y / N	☐ Tylenol (Acetaminophen)	Y / N
☐ Oxycodone (Percocet)	Y / N	☐ Aspirin	Y / N
☐ Codeine (Tylenol #3)	Y / N	☐ Ibuprofen (Advil, Motrin)	Y / N
☐ Hydromorphone (Dilaudid, Exalgo)	Y / N	☐ Meloxicam (Mobic)	Y / N
☐ Methadone	Y / N	☐ Celebrex (Celecoxib)	Y / N
☐ Butrans patch	Y / N	☐ Nabumetone (Relafin)	Y / N
☐ Morphine	Y / N	☐ Naproxen (Aleve)	Y / N
☐ Nucynta (Tapentadol	Y / N	☐ Diclofenac (Voltaren)	Y / N
☐ Oxycontin (Xtampza)	Y / N	☐ Etodolac (Lodine)	Y / N
☐ Oxymorphone (Opana)	Y / N	☐ Indomethacin	Y / N
☐ Tramadol (Ultram	Y / N	☐ Capsaicin Cream	Y / N
☐ Fentanyl (Duragesic)	Y / N	☐ Biofreeze	Y / N
☐ Belbuca	Y / N	☐ Bengay	Y / N
		☐ Lidocaine patch or ointment	Y / N

Muscle Relaxers	Did it help?	Nerve Medications	Did it help?
☐ Baclofen	Y / N	☐ Gabapentin (Neurontin)	Y / N
☐ Soma (Carisoprodol)	Y / N	☐ Lyrica (Pregabalin)	Y / N
☐ Cyclobenzaprine	Y / N	☐ Topamax (Topiramate)	Y / N
☐ Skelaxin (Metaxalone	Y / N	☐ Amitriptyline (Elavil)	Y / N
☐ Methocarbamol (Robaxin)	Y / N	☐ Cymbalta (Duloxetine)	Y / N
☐ Tizanidine (Zanaflex)	Y / N	☐ Zonegran (Zonisamide)	Y / N
☐ Chlorzoxazone (Lorzone)	Y / N	☐ Keppra (Levetiracetam	Y / N
☐ Orphenadrine (Norflex)	Y / N	☐ Gabitril (Tiagabine)	Y / N
		☐ Zoloft (Sertraline)	Y / N

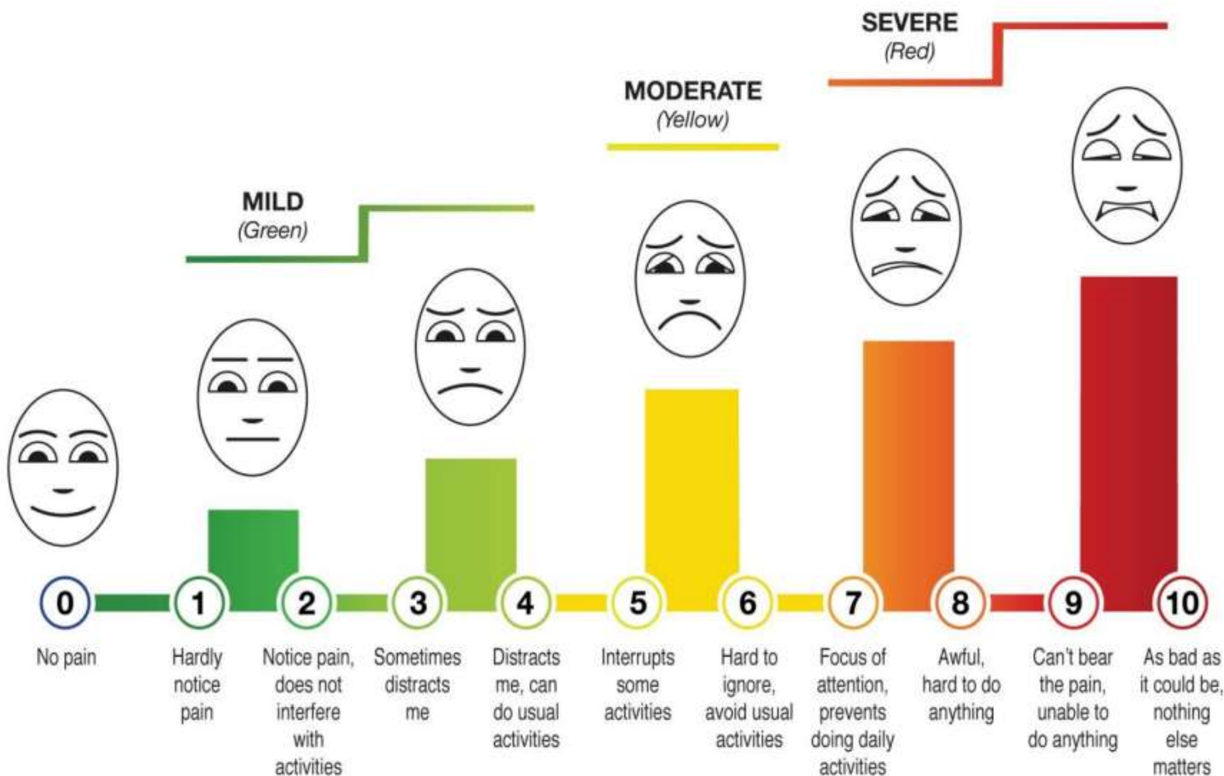
Associated symptoms:

Abdominal pain	Loss of bladder	Bladder retention	Loss of bowel	Decreased mobility	Diarrhea	Limping	Loss of balance
☐	☐	☐	☐	☐	☐	☐	☐

Rash	Sexual dysfunction	Tenderness	Tingling in the arms	Tingling in the legs	Weakness	Night pain	Constipation
☐	☐	☐	☐	☐	☐	☐	☐

Other: ____

Pain at its best: ________ /10 Pain at its worst: ________ /10 Pain score currently: ________ /10



Have you had any scans?	X-ray ☐ When/Where?	CT Scan ☐ When/Where?	MRI ☐ When/Where?
EMG ☐ When/Where?	Myelogram ☐ When/Where?	Bone Scan ☐ When/Where?	Other ☐ When/what type?

Medications: Please list name & dose including over the counter medications

Do you take any blood thinning medications? Please check below.

☐ Aspirin ☐ Coumadin (Warfarin) ☐ Plavix (Clopidogrel)

☐ Xarelto (Rivaroxaban) ☐ Effient (Prasugrel) ☐ Eliquis (Apixaban)

☐ Brilinta (Ticagrelor) ☐ Aggrenox (Dipyridamole) ☐ Lovenox (Enoxaparin)

☐Pradaxa (Dabigatran) ☐ NSAIDs ☐ Fish Oil or Vitamin E

Past Medical History

Please check all that apply: ☐ No Medical History

☐ Acid Reflux ☐ ADD/ ADHD ☐ AIDS/HIV ☐ Asthma ☐ Anxiety

☐ Cancer ☐ Depression ☐ Diabetes ☐ COPD/Emphysema ☐ Fibromyalgia

Type: Type 1 OR Type 2

☐ Gout ☐ Heart Disease ☐ Heart Attack ☐ Stroke ☐ High Blood Pressure

☐Pacemaker ☐ Hepatitis ☐ High Cholesterol ☐ Hypothyroidism ☐ Kidney Disease

☐ Liver Disease ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Nerve Damage ☐ Seizure Disorder

☐ Sleep Apnea ☐ Lupus ☐ Migraines ☐ Osteoporosis ☐ Atrial Fibrillation

☐Psoriasis ☐ Eczema ☐ Bipolar Disorder ☐ history of MRSA ☐ Ehlers-Danlos Syndrome

Other: ______________________________

Allergies

Do you have any medication allergies? YES ☐ NO ☐ **If yes, please list below:**

	Reaction:		Reaction:
	Reaction:		Reaction:
	Reaction:		Reaction:
	Reaction:		Reaction:

Past Surgical History

Do you currently have implanted devices such as pacemaker, defibrillator, stimulator, or pump? ☐Yes ☐No

Family History

Please check if any of your BLOOD relatives have any of the following:

DISEASE	RELATIONSHIP TO YOU
Asthma	
Bleeding Disorder	
Cancer (type)	
Chemical Dependency	
Diabetes	
Heart Disease	
High Blood Pressure	
Kidney Disease	
Neurologic Conditions	
Other, please list:	

☐ No known family history

Social History

Do you use tobacco products? ☐ No ☐ Former ☐ Yes Type: ______________ How many a day: __________

Years used: ______________ Have you ever tried to quit: ☐ Yes ☐ No Year quit: ______________

Do you drink alcohol: ☐ No ☐ Former ☐ Yes How often? ______________ Type: ______________

Do you use recreational drugs? ☐ No ☐ Former ☐ Yes How often? __________ Type: ______________

Do you have a history of alcohol or drug abuse? ☐ No ☐ Former ☐ Yes Any family history of alcohol or drug abuse? ☐ No ☐ Former ☐ Yes

Do you currently have an active suicidal thoughts? ☐ Yes ☐ No Any history of attempts? If yes, when? ______________

Marital Status: ______________ Do you have children? How many? ______________

What is your highest level of education? ______________

Do you exercise? ☐Yes ☐No How often? ______________

Employment

Are you currently working? ☐Yes ☐No Other: ______________ Occupation: ______________

Do you have work restrictions? ☐Yes ☐No If yes, explain: ______________

Are you retired? ☐Yes ☐No When? __________ Former Occupation: ______________

Review of Systems: Please circle all items that describe you currently

GENERAL: fever, fatigue weight loss, weight gain, weakness, night sweats, appetite changes

EYES: decreased vision, glasses or contacts, dryness, glaucoma, pain in eyes

ENT: decreased hearing, difficulty swallowing, hoarseness, sinus problems, ringing in ears, swollen glands

CARDIOVASCULAR: High blood pressure, chest pain, palpitations, shortness of breath, pacemaker, poor circulation, easy bruising, easy bleeding, use of a blood thinner, swelling of hands and feet

RESPIRATORY: Asthma, COPD, cough, bronchitis, wheezing, sputum

GASTROINTESTINAL: nausea, vomiting, constipation, crohn's disease, diarrhea, abdominal pain, blood in stool, decreased appetite, IBS

MUSCULOSKELETAL: neck pain, low back pain, joint pain, arthritis, muscle aches

SKIN: rash, eczema, itching, hives, skin cancer, skin lesions, nail changes

NEUROLOGIC: anxiety, seizures, memory loss, dizziness, fainting spells, paralysis, tremors, stroke, loss of bowel or bladder

GENITOURINARY: pregnant, incontinence, urgency, decreased libido, blood in urine, difficulty urinating

ENDOCRINE: cold intolerance, hair loss, hot flashes, diabetes, frequent urination, thyroid problems, heat intolerance

PSYCHIATRIC: bipolar, ADD/ADHD, depression, substance abuse, OCD, schizophrenia, delusions, eating disorder

Oswestry Questionnaire

Instructions: Please answer every section and mark only **ONE** box which applies to you currently. We realize you may consider 2 of the statements in any section, but please mark the box that most closely describes your current pain condition.

1. PAIN INTENSITY

- ☐ I can tolerate the pain I have without having to use pain killers
- ☐ The pain is bad, but I manage without taking pain killers
- ☐ Pain killers give complete relief from pain
- ☐ Pain killers give moderate relief from pain
- ☐ Pain killers give very little relief from pain
- ☐ Pain killers have no effect on the pain, & I do not use them

2. PERSONAL CARE (e.g. Washing, Dressing)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself & I am slow & careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help daily in most aspects of self-care
- ☐ I don't get dressed, I wash with difficulty & stay in bed

3. LIFTING

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

4. WALKING

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking more than one mile
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time & have to crawl to the toilet

5. SITTING

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than 1 hour
- ☐ Pain prevents me from sitting more than ½ hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

6. STANDING

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than one hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

7. SLEEPING

- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using medication
- ☐ Even when I take medication, I get less than 6 hrs sleep
- ☐ Even when I take medication, I get less than 4 hrs sleep
- ☐ Even when I take medication, I get less than 2 hrs sleep
- ☐ Pain prevents me from sleeping at all

8. SOCIAL LIFE

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting more energetic interests, i.e. dancing, etc
- ☐ Pain has restricted my social life & I don't go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

9. TRAVELING

- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad, but I manage journeys over 2 hours
- ☐ Pain restricts me to journeys of less than 1 hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/HOMEMAKING

- ☐ My normal homemaking/ job activities do not cause pain
- ☐ My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me
- ☐ I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties
- ☐ Pain prevents me from doing even light duties
- ☐ Pain prevents me from performing any job or homemaking chores

General Consent and Authorization for Treatment, Evaluation, and Information Release

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time.

I certify that my medical history is complete and accurate to the best of my knowledge and ability.

I voluntarily request that Pain Physicians of Wisconsin/Pro Spine & Pain provider pain management care, treatment, and services to me, as deemed reasonable and necessary by the assigned healthcare provider(s). I consent to reasonable and necessary medical examination, evaluation, testing and treatment which may include diagnostic, radiology, and laboratory procedures. I understand I may be asked to provide to provide urine, oral swab, and/or blood samples. I have the right to refuse specific tests but understand this may impact my pain management treatment. If invasive, interventional treatment is recommended, I will be informed of the benefits and risk prior to performance of such treatment and will be provided with a separate consent form outlining such benefits and risks.

PHOTOGRAPHS I consent to taking and reproducing pictures of me in any form (e.g., photography, film, tape, etc.) in connection with my diagnosis, care, and treatment (including surgical procedures). These pictures will be used for purposes related to treatment, scientific and educational purposes, billing, coordination of care, and healthcare operations, such as quality assurance, patient safety and identification.

RELEASE OF INFORMATION I specifically authorize the uses and disclosures of my health information as described in the Notice of Privacy Practices provided to me. I authorize Pain Physicians of Wisconsin/Pro Spine & Pain physicians, and/or their staff, to obtain my medication history and other relevant health care information, verbally, written or electronically, that is deemed necessary for my treatment. I consent to release of my health information to federal or state health plans, insurance companies, collection agencies, employers, or other organizations responsible for payment of services, as appropriate. I understand that this may include information relating to my diagnosis, care, payment for my care, or demographic information.

BY SIGNING BELOW, I AM AGREEING TO THE CONSENTS AND RELEASES DESCRIBED ON THIS FORM. I HAVE READ THIS CONSENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

Printed Patient Name: ____

Signature of Patient or Authorized Representative: _______________________________________

Date: _____________

PPW Health/Pro Spine & Pain

Financial Policy

Welcome to PPW Health/Pro Spine & Pain! We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship. Please carefully review this Financial Policy, initial each section, and sign the agreement to indicate your acceptance of its terms.

Payment is Due at the Time of Service

1. All co-payments, deductibles, coinsurance, and fees for non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment. If you arrive without your co-payment, we may ask you to reschedule your appointment. We accept credit/debit cards, money orders, and personal checks.

2. In the event you need a procedure, we can provide an estimate of your insurance required deductible and co-insurance amounts. Prepayment of this estimate is due at the time the procedure is scheduled or by phone prior to the procedure date. We reserve the right to reschedule your procedure until prepayment arrangements have been made. You are responsible for any unpaid balance after your insurance carrier has processed your claim.

3. Patient-responsible balances are due when you check in for your appointment.

4. We designate accounts **Self-Pay** under the following circumstances: (1) patient does not have health insurance coverage, (2) patient is covered by an insurance plan that our providers do not participate in, (3) patient does not have a current, valid insurance card on file, or (4) patient does not have a valid insurance referral on file.

5. We request at least **24-hours** advanced notice be given to the office if you will be unable to keep your scheduled appointment. This allows us to release your appointment time to another patient. You will be charged a fee for each incident according to the Public Fee Schedule. These charges are your personal responsibility and will not be billed to any insurance carrier. Patients who repeatedly "no show" for appointments may be discharged from the practice.

Initial: _____

Proof of Insurance

1. Please bring your insurance card(s) and a valid photo ID with you to each appointment.

2. It is your responsibility to notify the Practice in a timely manner of changes in your health insurance coverage. If the Practice is unable to process your claim within your health insurance carrier's filing limits, or lack of your response to insurance carrier inquiries due to untimely notice, you will be responsible for all charges.

3. If we are not part of your insurance carrier's network (out of network) or **your insurance carrier pays you directly, you are obligated to forward the payment immediately to the Practice.**

Initial: _____

Referrals and Authorization

1. The Practice has specific network agreements with many insurance carriers, but not all insurance carriers. **It** is your responsibility to contact your insurance carrier to verify that your assigned provider participates in your plan. Your insurance carrier's plan may have out-of-network charges that have higher deductibles and co-payments, which are your responsibility.

2. If you have an HMO plan that we are contracted with, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, call your primary care physician to obtain it. Without an insurance required referral, the insurance company will deny payment for services. As such, if you are unable to obtain the referral at that time, you will be rescheduled or asked to pay for the visit in advance. As a matter of course, the Practice will inform your referring physician of your patient care plan and progress either by using any secure electronic transmission or by an employee of the practice.

3. The Practice may provide services that your insurance carrier's plan excludes or requires prior authorization. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf. Ultimately, it is your responsibility to ensure that services provided to you are covered benefits and authorized by your insurance carrier.

Initial: _____

Billing and Refunds

1. If we must send you a statement, the balance is due in full within 30 days of the statement date.

2. If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney for collection. This may result in adverse reporting to credit bureaus and additional legal action. **<u>The Practice reserves the right to refuse treatment to patients with outstanding balances over 120 days old</u>**. You agree, to service your account or to collect any amounts you may owe, we may contact you at any telephone number associated with your account, including cellular numbers, which could result in charges to you. We may also contact you by text message or e-mail, using any e-mail address you provide.

3. You will be charged a fee for returned checks according to the Public Fee Schedule.

4. Our Practice treats patients regardless of financial status. We offer financial assistance in the form of a sliding scale discount based on verifiable household income.

5. If you make an overpayment on your account, we will issue a refund only if there are no other outstanding balances for medical services on your account or any other account(s) with the same financial responsible party.

Initial: _____

Additional Information

1. The Privacy Rule allows you to receive a copy of your personal medical and billing records and allows the Practice to require individuals to complete and sign an Authorization for Disclosure and Release of Medical Records Form.

2. The Practice will respond (at the provider's discretion) to requests for the completion of certain medical forms (FMLA, Short Term Disability & Temporary Disability Parking Permit) assuming the patient is in good standing and has been active with the Practice for six (6) months consecutively. All requests require an office visit.

3. By initialing this section, I acknowledge that I have received and reviewed, or have been given opportunity to receive and review, a copy of the Practice's Notice of Privacy Practice.

4. By initialing this section, I acknowledge that I have received a copy of the Statement of Patient's Rights.

5. By initialing this section, I acknowledge that I have received a copy of the Advanced Directive Statement.

Initial: _____

Practice Code of Conduct

We are pleased to serve you and glad that you chose Pain Physicians of Wisconsin/Pro Spine & Pain as your new pain management provider. We will always strive to provide exceptional care for you.

Reasons that Pain Physicians of Wisconsin/Pro Spine & Pain may ask you to seek health care services elsewhere might include:

- Rude or violent behavior to staff via in-person or telephone - this also applies to your family members and/or friends.
- Repeated no shows, cancellations, or continual late arrivals for office visits or procedures.
- Refusal to adhere to the plan of care as outlined by your provider or to follow health insurance or government guidelines.
- Unwarranted requests for disability paperwork.

Our goal is to help you. Therefore, we ask that you schedule and keep all follow up appointments, participate in all treatments and diagnostic testing.

Initial: _____

Public Fee Schedule

ITEM	FEE CHARGED
Failure to Cancel your Appointment within 24 hours of the schedule time.	$50.00 per Clinic incident $100.00 per Procedure
No Show for your appointment.	$50.00 per Clinic incident $100.00 per Procedure *Any additional applicable costs associated with your visit may also be applied*
Late Arrivals- if you arrive 15 minutes past your arrival time, and we must reschedule your appointment.	$50.00 per Clinic incident $100.00 per Procedure or EMG appointment
Return Check Fee.	$15.00 plus bank fees per incident
Completion of Disability Forms	Costs below are per each occurrence: **FMLA** - $50.00 each completion **Temporary Disabled Parking Permit** - $5.00 **Short Term Disability Form** - $25.00

By initialing this section, I acknowledge that I have read the Public Fee Schedule.

Initial: _____

Printed Patient Name: ____

Signed:____ Date: ______________________

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPM) Privacy Standards.

Print Name of Patient:____**Date of Birth:** ____________________

I. My Authorization

I authorize Pain Physicians of Wisconsin/Pro Spine & Pain, its agents, and employees to use or disclose the following health information.

All of my health information

My health information for the following condition(s): ____

I do not authorize disclosure of my health information.

The above party may disclose this health information to the following recipient{s), please include medical providers, family, and friends:

Name, relationship and/or organization: ____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and Is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Signature of Patient:____Date: ____________________________

If the patient is a minor or unable to sign, please complete the following:

Patient is a minor.__________________years of age

Patient is unable to sign because: ____

Signature of Authorized Representative: ____ Date: _________

Print Name of Authorized Representative: ____

Authority of representative to sign on behalf of the patient:

Parent Legal Guardian Court Order Other: ________________________________

III. Additional Consent for Certain Conditions

This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before the information can be released.

I consent to have the above information released. ____

I do not consent to have the above information released. ____

Printed Patient Name: ____

Signature of Patient or Authorized Representative: ___________________________________ Date: __________

Notice of Privacy Practice

Effective Date March 2023

This Notice Describes How Medical Information About You May Be Used, Disclosed and How You Can Get Access to This Information. PLEASE REVIEW IT CAREFULLY.

Our Pledge Regarding Medical Information:

We understand that medical information about you and your health is personal. We are committed to protecting medical information In a reasonable and appropriate manner. We create a record of the care and the services you receive at Pain Physicians of Wisconsin/Pro Spine & Pain and its affiliates. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by our Practice. This notice will tell you about the ways in which we may use and disclose medical information about you, your rights, and certain obligations we have regarding the use and disclosure of medical information. We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and practices concerning medical information about you; and
- follow the terms of this notice that is currently in effect.

How We May Use and Disclose Medical Information About You.

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing our Privacy Officer.

- For Treatment: We can use your Health Information and share it with other professionals who are treating you.
- For Payment: We can use and share your Health Information to bill and get payment from health plans or other entities.
- For Health Care Operations: We can use and share your Health Information to run our practice, improve your care, and contact you when necessary.
- Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services: We can share and disclose Health Information to contact you to remind you that you have an appointment with us. We may also use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.
- Individuals Involved in Your Care or Payment for Your Care: When appropriate, we can share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend.
- Research: Under certain circumstances, we can share and disclose Health Information for research. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.
- As Required by Law: We can share and disclose Health Information about you when required to do so by federal, state, or local laws.
- To Advert a Serious Threat to Health or Safety: We can share and disclose Health Information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- For All Other Uses and Disclosures: All other uses and disclosures of information not contained in this Notice of Privacy Practices will not be disclosed without your authorization.
- Organ and Tissue Donation: We can share Health Information about you with organ procurement organizations.
- Workers' Compensation, Law Enforcement and Other Government Agencies: We can share Health Information about you for workers' compensation, for law enforcement purpose and healthcare oversight agencies for activities authorized by the law, or special government functions such as military, national security and presidential protection.
- Public Health Risks: We can share Health Information about you for certain situations:
  - to prevent or control disease;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products that they may be using;
  - notify a person who may have been exposed to a disease or may be at risk.
- Lawsuits and Legal Disputes: We can share Health Information about you in response to a court or administrative order, or in response to a subpoena.
- Comply with the Law: We will share information about you if state or federal laws require it, including with Health and Human Services should it want to see we are complying with federal privacy law.
- Coroners, Medical Examiners and Funeral Directors: We can share Health Information to a coroner, medical examiner, or funeral director when an individual die.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt-Out.

In these cases, you can tell us what we can share:

1. Share information with your family, close friends. or others involved in your care.
2. Share information in a disaster relief situation.
3. Include your information in a hospital directory.
4. Contact you for fundraising efforts. We may contact you, but you can tell us not to contact you again.

Your Written Authorization Is Required for Other Uses and Disclosures.

In these cases, we never share your information unless you have given us written permission:

1. Marketing Purposes
2. Sale of your information
3. Sharing of psychotherapy notes

*If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But any disclosure that we made in reliance on your authorization **before** you revoked it will not be affected by the revocation.*

Your Rights.

You have the following rights regarding Health Information we have about you:

- Right to Inspect and Obtain a Copy of Your Medical Records: You can ask to see or get an electronic copy of your medical record or other health information we have about you. If your Protected Health Information is maintained in an electronic format, you have the right to request that an electronic copy of your records be given to you or transmitted to another Individual or entity. We will provide a copy or a summary of your Health Information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

- Right to Correct Your Medical Records: You can ask us to correct health information about you that you think is incorrect or incomplete. We may also say "no" to your request, but we will tell you why in writing within 60 days. To request an amendment, you must make your request, in writing, to our Privacy Officer.

- Right to an Account of Disclosures: You can ask us for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except those about treatment, payment, and health care operations, and certain other disclosures. We will provide one accounting per year for free. There will be a reasonable, cost-based fee If you ask for another accounting within the 12-month period. To request an accounting of disclosures, you must make your request. in writing, to our Privacy Officer.

- Right to Limit Information We Share: You have the right to ask us not to use or share certain Health Information for treatment, payment, or health care operations. We are required to agree to your request unless it would affect your care. If you pay for services out-of-pocket in full, for a specific item or service, you can ask that your Protected Health Information is not shared with your health insurer for the purposes of payment. We will say yes unless a law requires us to share that information.

- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing to our Privacy Officer. We will say yes to all reasonable requests.

- Right to a Paper Copy of This Notice. You have right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy, contact our Privacy Officer.

- Changes to this Notice. We reserve the right to change this notice and make a new notice that applies to the Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.

- **Complaints**: If you believe your privacy rights have been violated, you may file a complaint with our office by contacting the Secretary of Health and Human Services at www.hhs.gov/ocr/privacy/hipaa/complaints/. All complaints must be in writing. You will not be penalized for filing a complaint.

Printed Patient Name: ____

Signature of Patient or Authorized Representative: ______________________________Date: ______________________

STATEMENT OF PATIENT RIGHTS

Patients Have the Right To:

- Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
- Receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
- Receive privacy in treatment and care for personal needs;
- Review, upon written request, the patient's own medical record according to A.RS. §§ 12-2293, 12-2294, and 12-2294.01;
- Receive a referral to another health care institution **if** this facility is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
- Participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
- Participate or refuse to participate in research or experimental treatment;
- Receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights;
- Be treated with dignity, respect, and consideration;
- Not be subjected to abuse, neglect, exploitation, coercion, manipulation, sexual abuse, sexual assault or except as allowed in R9- 10-1012(8), restraint or seclusion;
- Not be subjected to retaliation for submitting a complaint to the Department or another entity;
- Not be subjected to misappropriation of personal and private property by any clinic personnel member, employee, volunteer, or student;
- Consent to or refuse treatment, except in an emergency and to refuse or withdraw consent for treatment before treatment is initiated;
- Be informed of alternatives to medications or surgical procedure and associated risks and possible complications of medications or surgical procedure, except in an emergency;
- Be informed of the clinic's policy on health care directives, and the patient complaint process;
- Consent to photographs before a patient is photographed, except that a patient may be photographed for identification and administrative purposes;
- Provide written consent to the release of information in the patient's medical records or financial records, except as otherwise permitted by law.

Patients Have the Responsibility To:

- Be honest about matters that relate to you as a patient.
- Provide staff with accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters pertaining to your health.
- Report any perceived risks in your care.
- Report any unexpected changes in your condition to those responsible for your care and welfare.
- Follow the care, service, or treatment plan developed.
- Ask any questions when you do not understand or have concerns about your plan of care.
- Understand the consequences of the treatment alternatives and not following your plan of care.
- Know the staff who are caring for you.
- Be considerate and respectful of the rights of both fellow patients and staff.
- Honor the confidentiality and privacy of other patients.
- Be considerate of the property of Pain Physicians of Wisconsin/Pro Spine & Pain.
- Assure the financial obligations of your healthcare are fulfilled as promptly as possible.

Printed Patient Name: ____

Signature of Patient or Authorized Representative: ______________________________________Date: ________________________