Patient Name:

_____

Jessica Fuller-Hines, MD, F.A.A.P.M.R.

Jessica Gorr, DO, F.A.A.P.M.R.

Brooke Jennings, PA-C

Kara Waldrop, FNP

Saree Allen, FNP

Your Appointment Date:

_____

Your Appointment Time:

_____

Your Provider:

_____

Locations:

Elizabeth City

135 E Rich Blvd, Elizabeth City NC 27909

Phone: 252-333-1277

Fax: 252-333-1877

Kitty Hawk (Gorr Only)

12 Juniper Tr. Unit 102

Kitty Hawk, NC 27949

Phone: 252-715-1032

Fax: 252-715-0700

Comprehensive Rehabilitation & Pain Specialists, P.C.

Jessica Fuller-Hines, M.D.
Jessica H. Gorr, D.O.

135 Rich Blvd, Elizabeth City, NC 27909
(252) 333-1277

Thank you for choosing Comprehensive Rehabilitation & Pain Specialists. **Please complete our new patient forms completely and send back for appointment. If your forms are not complete we cannot schedule an appointment.**

Remember to bring your insurance identification card and picture ID. It is important that you **arrive 20 minutes** early to complete patient check-in. **Late arrival** for your appointment may result in it being **rescheduled.**

It is essential that you bring with you any medical records and x-ray reports in order to assist the physician in determining your treatment. Records may also be faxed to 252-333-1877 prior to your appointment to the attention of the doctor with whom you have the appointment. Be sure to include your name and your referring physician's name on your fax cover sheet. Please contact our office to ensure all information has been received.

At the time of your visit, you will be expected to provide payment in the amount of any co-payment required by your insurance plan, coinsurance, and any unmet annual deductible amount where appropriate, and for any services that are not covered. Payments can be in the form of cash, check or credit card.

We look forward to serving you. Should you have any questions, please call us at 252-333-1277 or visit our website at www.crps.biz.

Please also ask about enrolling onto our new **Patient Portal** to virtually view and edit your information in your medical records, request appointments and view upcoming appointments. At Comprehensive Rehabilitation & Pain Specialists we strive to provide the highest quality of care to our patients.

Comprehensive Rehabilitation & Pain Specialists, P. C.

135 Rich Blvd.
Elizabeth City, NC 27909
Ph 252 333-1277
Fax 252 333-1877

Authorization

To be completed by the health care provider:

Patient Name: _____ **Patient D.O.B #:** _____

Persons/organization providing the information:

Persons/organization receiving the information:
Comprehensive Rehabilitation & Pain Specialists,P.C.
135 E. Rich Blvd
Elizabeth City, NC 27909
252-333-1277 Fax 252-333-1877

Specific description of information including dates(s):
Please copy and transfer all my medical records, for all dates of service, to Comp Rehab at the above address.
By initialing the appropriate spaces, I authorize the release of this information:
_____ HIV/AIDS RECORDS
_____ DRUG/ALCOHOL RECORDS
_____ MENTAL HEALTH TREATMENT RECORDS

The information described above will be used or disclosed for the following purpose(s):

Expiration date:
This authorization will expire: ☐ 60 days ☒ 90 days or ☐ Other _____ from date signed.

To be completed by the patient or personal representative:

I hereby authorize the use or disclosure of my protected health information as described above.

I understand that this authorization is voluntary. I understand that the ability to obtain treatment will not be affected if I do not sign this form, unless that treatment is for a fitness-for-duty evaluation or a research-related treatment.

I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations, then such information may be redisclosed and will no longer be protected.

I understand that I have a right to revoke this authorization by sending written notification to: The Facility Privacy Officer at the above address. Any revocation will not affect disclosures made prior to C.R.P.S. receipt or knowledge of the revocation.

I understand that I have a right to inspect and receive a copy of the information described on this form.

I certify that I have received a copy of this authorization.

_____ _____
Signature of patient or patient's representative **Date**

Printed name of patient's representative: _____

Relationship to the patient: _____

Witness: _____

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(252) 333-1277

PATIENT INFORMATION

Patient Name: DOB: Date:

Address: City State Zip

Home phone #: Cell #: Social Security #:

Primary Language Spoken: Race:

Ethnicity (Please check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

State of License: Primary Care Physician:

Driver License #: Referring Physician:

Employer's Name & Address: Employer Phone #:

Email: Married Single Divorced Widowed

Spouse's Name: Social Security #:

Spouse's Employer: Employer's Phone #:

Spouse's Employer Address:

Does the patient have health insurance? ☐ Yes ☐ No

If your response was yes, please list the insurance company's names. Please have your insurance cards available to copy.

Primary Insurance Carrier: _____ ID#_____

Secondary Insurance Carrier:_____ ID#_____

Subscriber's relationship to patient (wife, husband, etc.):_____ Subscriber DOB: _____
Subscriber's Gender:_____Subscriber SSN:_____ Subscriber I.D. # _____

I hereby authorize release of information necessary to file a claim(s) with my insurance company and assign benefits otherwise payable to me to Comprehensive Rehabilitation & Pain Specialists.

I understand I am financially responsible for any balance not covered by my insurance carrier.

A copy of this signature shall be as valid as the original.

Patient Signature:

Witness Signature:

Emergency Contact:

Phone #: Cell #: Relationship:

Comprehensive Rehabilitation & Pain Specialists, P.C.
FINANCIAL POLICY

As your physician, I am committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.

FINANCIAL RESPONSIBILITY
I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Comprehensive Rehabilitation & Pain Specialists. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED
We accept cash, personal checks, MasterCard and Visa. Returned checks are subject to a $25.00 service fee and you will lose your privilege to write checks in our offices. If you are a self-pay patient your 1st visit can be paid only by cash or credit. No checks will be accepted.

HMO/PPO INSURANCE COVERAGE
CO-PAYMENT, COINSURANCE AND DEDUCTIBLE MUST BE PAID AT THE TIME OF SERVICE. I understand that it is my responsibility to provide Comprehensive Rehabilitation & Pain Specialists with a copy of my current insurance card and, if required by my insurance, to obtain a referral from my primary care physician. Comprehensive Rehabilitation & Pain Specialists is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a self-pay patient and I am financially responsible for the total amount of the services provided. I will notify Comprehensive Rehabilitation & Pain Specialists immediately upon any change to my insurance. We will file your insurance if we are under contract with your insurance company. I understand that all charges not covered by my insurance are my responsibility. If the insurance company fails to pay Comprehensive Rehabilitation & Pain Specialists in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to Comprehensive Rehabilitation & Pain Specialists.

HEALTH INSURANCE EXCHANGE POLICIES
If your policy was purchased on the Health Insurance Exchange, our office requires a receipt of your premium paid for the month of your visit. If you are unable to provide proof of premium payment, you are responsible for paying the allowable for the services provided at the time of service. If your insurance company pays, that money will be refunded.

MEDICARE
Your deductible and 20% of the allowable charges are due at the time of service. We are Medicare providers. We will file your Medicare. I hereby authorize and assign all payments of authorized Medicare benefits for medical services and/or procedures rendered to patient, directly to Comprehensive Rehabilitation & Pain Specialists. I hereby authorize Comprehensive Rehabilitation & Pain Specialists to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by Medicare for which I have signed an Advance Beneficiary Notice ("ABN"). If we do not know the allowable charge for a specific service, you will be billed after payment is received from Medicare. Please bring your Medicare Explanation of Benefits to show that you have met your deductible for the year.

WORKER'S COMPENSATION
We will call your employer to authorize your visit prior to your appointment. We will file with your company's insurance.

AUTOMOBILE ACCIDENTS
We will file your claim(s) under your private insurance company when you are involved in an automobile accident; however, it is your responsibility to provide us with your insurance information so that we can verify your coverage. You will be responsible for payment of your portion at the time you receive medical treatment.

LABORATORY BILLING PROCEDURE
I have been informed that all laboratory procedures done outside of the office (blood work, urine drug screenings, etc.) will not be included in the charges for Comprehensive Rehabilitation & Pain Specialists. All lab tests performed by an outside laboratory are billed separately to either my insurance company or myself. I understand that all charges not covered by my insurance are my responsibility. I will direct any questions regarding a bill or statement from an outside laboratory to the lab.

NO SHOW POLICY (Please initial) If you are 10 minutes or more late your appointment it will be rescheduled.
There will be a $25.00 charge if you fail to show for your scheduled office appointment. It is your responsibility to notify the office 24 hours in advance if you are unable to keep your office appointment.

There will be a $100.00 charge if you fail to show for your scheduled procedure appointment. It is your responsibility to notify the office 24 hours in advance if you are unable to keep your procedure appointment.

CONSENT FOR MEDICAL TREATMENT

I am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize care encompassing the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations performed. This form has been fully explained to me and I certify that I understand and accept its contents as noted.

RELEASE OF MEDICAL INFORMATION

I hereby authorize Comprehensive Rehabilitation & Pain Specialists to release financial, medical and such other information as may be requested by any insurer or other party who may be liable for any part of the charges of my care. I authorize Comprehensive Rehabilitation & Pain Specialists to contact my employer and insurance carrier to verify coverage of my insurance. My signature shall authorize Comprehensive Rehabilitation &Pain Specialists to obtain copies of medical records from previous treating physicians and/or facilities where diagnostic testing may have been performed.

FORM COMPLETION FEE

Due to the large volume of forms that we are required to complete, our office reserves the right to charge up to $15.00 per page for the completion of forms. Dictated letters are dealt with on a case-by-case basis. Medical records fees are $0.50 per page for the 1st 50 pages and $0.25 per page thereafter. Turnaround time is 1 week.

PRIVACY POLICY

I have received a copy of Comprehensive Rehabilitation & Pain Specialist's privacy policy and have been given the opportunity to have my questions, if any, answered.

FINANCIAL AGREEMENT

We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that: • Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. • Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company.

ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.

Collection action will be taken for any charges, including those that insurance has not paid, older than 90 days. A service fee of 33 1/3% of your balance will be added to your account if sent to collections. We realize that emergencies do arise that may affect timely payment of your account. If extreme circumstances occur, please contact us promptly for assistance in the management of your account.

I do hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to Comprehensive Rehabilitation & Pain Specialists. In the event I receive payment directly from my insurance company for services rendered by Comprehensive Rehabilitation & Pain Specialists, I agree to endorse any check received to Comprehensive Rehabilitation & Pain Specialists.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Date: _____

Patient Signature: _____

Printed Name of Patient: _____

Parent, Guardian or Legal Representative Signature: _____

Printed Name of Parent, Guardian or Legal Representative: _____

Legal Representative's Authority to Act for Patient (Power of Attorney, Healthcare Surrogate): _____

Comprehensive Rehabilitation
& Pain Specialists, P.C.
Jessica Fuller-Hines, M.D.
Jessica H. Gorr, D.O.
135 Rich Blvd, Elizabeth City, NC 27909
(252) 333-1277

www.comprehabandpain.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Comprehensive Rehabilitation & Pain Specialists (CRPS), we are committed to treating and using protected health information ("PHI") about you responsibly. This Notice of Privacy Practices ("Notice") describes the personal information we collect, and how and when we use or disclose that information.

Understanding Your Health Record/Information

Each time you visit CRPS; a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information may be used or disclosed to:

- Plan your care and treatment.
- Communicate with other providers who contribute to your care.
- Serve as a legal document.
- Receive payment from you, your plan, or your health insurer.
- Assess and continually work to improve the care we render and the outcomes we achieve.
- Comply with state and federal laws that require us to disclose your PHI.

Understanding what is in your record and how your PHI is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your PHI, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of CRPS, the information belongs to you. You have the right to request to:

- Access, inspect and copy your health record. You have the right to inspect and/or request a paper copy of your medical record. You have the right to request an electronic copy of your medical record be given to you or transmitted to another individual or entity. CRPS may charge you a reasonable, cost-based fee for the labor and supplies associated with copying or transmitting the electronic PHI.
- Amend your health record which you believe is not correct or complete. CRPS is not required to agree to the amendment if you ask us to amend information that is in our opinion: (i) accurate and complete; (ii) not part of the PHI kept by or for CRPS; (iii) not part of the PHI which you would be permitted to inspect and copy; or (iv) not created by CRPS, unless the individual or entity that created the information is not available to amend the information. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.
- Obtain a written accounting of certain non-routine disclosures of your PHI. We are not required to list certain disclosures, including (i) disclosures made for treatment, payment, and health care operations purposes, (ii) disclosures made with your authorization, (iii) disclosures made to create a limited data set, and (iv) disclosures made directly to you. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years prior to the date of your request. If the CRPS office where you receive services maintains your medical records in an EMR system, you may request that the accounting include disclosures for treatment, payment and health care operations for the three (3) years prior to the date of such request. You must submit your request in writing to the Privacy Officer. The first list you request within a 12-month period is free of charge, but CRPS may charge you for additional lists within the same 12-month period. CRPS will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
- Communications of your PHI by alternative means (e.g. e-mail) or at alternative locations (e.g. post office box).
- Place a restriction to certain uses and disclosures of your information. In most cases CRPS is not required to agree to these additional restrictions, but if CRPS does, CRPS will abide by the agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). CRPS must comply with a request to restrict the disclosure of PHI to a health plan for purposes of carrying out payment or health care operations if the PHI pertains solely to a health care item or service for which we have been paid out of pocket in full.
- Revoke your authorization to use or disclose PHI except to the extent that action has already been taken.

Our Responsibilities

CRPS is required to:

- Maintain the privacy of your PHI.
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of the Notice currently in effect
- Notify you in writing if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate PHI by alternative means or at alternative locations.
- Notify you in writing of a breach where your unsecured PHI has been accessed, acquired, used or disclosed to an unauthorized person. "Unsecured PHI" refers to PHI that is not secured through the use of technologies or methodologies that render the PHI unusable, unreadable, or indecipherable to unauthorized individuals.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, such revised Notices will be made available to you.

We will not use or disclose your PHI without your written authorization, except as described in this Notice.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact:

Privacy Officer
Comprehensive Rehabilitation & Pain Specialist's, P.C.
135 E. Rich Blvd
Elizabeth City, NC 27909
Telephone: (252) 333-1277

If you believe your privacy rights have been violated, you can file a written complaint with CRPS's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the address. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Treatment: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your medical record and used to determine the course of treatment that should work best for you. To promote quality care, CRPS operates an EMR. This is an electronic system that keeps PHI about you.

CRPS may also provide a subsequent healthcare provider with PHI about you (e.g., copies of various reports) that should assist him or her in treating you in the future. CRPS may also disclose PHI about you to, and obtain your PHI from, electronic PHI networks in which community healthcare providers may participate to facilitate the provision of care to patients such as yourself.

CRPS may use a prescription hub which provides electronic access to your medication history. This will assist CRPS health care providers in understanding what other medications may have been prescribed for you by other providers.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, diagnosis, procedures, and supplies used.

Health Care Operations: We may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates: We may contract with third parties to perform functions or activities on behalf of, or certain services for, CRPS that involve the use or disclosure of PHI and disclose your PHI to our business associate so that they can perform the job we've asked them to do. We require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication from Offices: We may call your home or other designated location and leave a message on voice mail, in reference to any items that assist CRPS in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, insurance items and any call pertaining to your clinical care. We may mail to your home or other designated location any items that assist CRPS in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, patient satisfaction surveys and patient statements.

Communication with Family/Personal Friends: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, PHI relevant to that person's involvement in your care or payment related to your care. When a family member(s) or a friend(s) accompany you into the exam room, it is considered implied consent that a disclosure of your PHI is acceptable.

Open Treatment Areas: Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, others may overhear some patient information while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our Privacy Officer.

To Avert a Serious Threat to Health or Safety: We may use your PHI or share it with others when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public.

Coroners, Medical Examiners and Funeral Director: In the unfortunate event of your death, we may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

Deceased Individuals: In the unfortunate event of your death, we are permitted to disclose your PHI to your personal representative and your family members and others who were involved in the care or payment for your care prior to your death, unless inconsistent with

any prior expressed preference that you provided to us. PHI excludes any information regarding a person who has been deceased for more than 50 years.

Organ Procurement Organizations: Consistent with applicable law, we may disclose PHI to organ procurement organizations, federally funded registries, or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you by mail, e-mail or text to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. However, we must obtain your prior written authorization for any marketing of products and services that are funded by third parties. You have the right to opt-out by notifying us in writing.

Sale of PHI: CRPS may not "sell" your PHI (i.e., disclose such PHI in exchange for remuneration) to a third party without your written authorization that acknowledges the remuneration unless such an exchange meets a regulatory exception.

Health Oversight Activities: We may release your PHI to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs, such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health: As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability..

Workers Compensation: We may disclose PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Law Enforcement: We may disclose PHI for law enforcement purposes as required by law.

Inmates and Correctional Institutions: If you are an inmate or you are detained by a law enforcement officer, we may disclose your PHI to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety at the place where you are confined.

Lawsuits and Disputes: We may disclose your PHI if we are ordered to do so by a court that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

As Required by Law: We may use or disclose your PHI if we are required by law.

Comprehensive Rehabilitation
& Pain Specialists, P.C.
Jessica Fuller-Hines, M.D.
Jessica H. Gorr, D.O.
135 Rich Blvd, Elizabeth City, NC 27909
(252) 333-1277

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION
We are required by law to maintain the privacy of protected health information ("PHI"). PHI includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. This notice also discusses the uses and disclosures we will make of your PHI. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI we maintain. You can always request a copy of our most current privacy notice from our office.

PERMITTED USES AND DISCLOSURES
The following categories describe the different ways in which we may use and disclose your PHI without obtaining your authorization:
• Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Therefore, the doctor may review your medical records to assess whether you have potentially complicating conditions like diabetes.
• Payment means activities we undertake to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, prior to providing health care services, we may need to provide to your HMO information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the HMO for the services rendered to you, we can provide the HMO with information regarding your care if necessary to obtain payment.
• Health care operations means the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective.
• We have an indirect treatment relationship with you, that is, we provide health care to you based on the orders of another health care provider. For example, if you have come to us for a diagnostic procedure, we can disclose the results of that test to the physician who ordered the procedure.

OTHER USES AND DISCLOSURES OF PHI
We may contact you to notify you of lab or test results, to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

We may disclose your PHI only to those people that you have authorized. We will only disclose the PHI directly relevant to their involvement in your care or payment. We may also use or disclose your PHI to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your

location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the PHI that is directly relevant to their involvement in your care. When permitted by law, we may coordinate our uses and disclosures of PHI with public or private entities authorized by law or by charter to assist in disaster relief efforts.

We will allow your family and friends to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, and similar forms of PHI with your authorization.

Except for the special situations listed below, we will not use or disclose your PHI for any other purpose unless you provide written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

SPECIAL SITUATIONS

• Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

• Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

• Worker's Compensation: We may release medical information about you for programs that provide benefits for work-related injuries or illness.

• Public Health Risks: We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of product, recalls, repairs or replacements;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

• Health Oversight Activities: We may disclose medical information to federal or state agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. We may disclose PHI to persons under the Food and Drug Administration's jurisdiction to track products or to conduct post-marketing surveillance.

• Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;

• About a death we believe may be the result of criminal conduct;
• About criminal conduct on our premises;
• In emergency circumstances to report a crime, the location of the crime or victims or the identity, description or location of the person who committed the crime.

• Coroners, Medical Examiners and Funeral Directors: We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.
• National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counter- intelligence, or other national security activities authorized by law.

• Protective Services for the President and Others: We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
• Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
• Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose PHI if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

YOUR RIGHTS
1. Requesting Restrictions: You have the right to request restrictions on our uses and disclosures of PHI for treatment, payment and health care operations. However, we are not required to agree to your request. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Practice Office Manager at your treating location (252) 333-1277. Your request must describe in a clear and concise fashion:
a) The information you wish restricted;
b) Whether you are requesting to limit our practice's use, disclosure or both; and
c) To whom you want the limits to apply.

2. Confidential Communications: You have the right to reasonably request to receive communications of PHI by alternative means or at alternative locations. However, you are required to provide our office with a daytime telephone number.
3. Inspection and Copies: You have the right to inspect and copy the PHI contained in your medical and billing records, except for:
i. psychotherapy notes, which are notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record;
ii. Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
iii. PHI involving laboratory tests when your access is required by law;
iv. if you are a prison inmate and obtaining such information would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you;
v. if we obtained or created PHI as part of a research study for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;
vi. Your PHI is contained in records kept by a federal agency or contractor when your access is required by law; and
vii. If the PHI was obtained from someone other than us under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

We may also deny a request for access to PHI if:
• a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person;

• the PHI makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or • the request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person.

If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.

4. Requesting an Amendment: You have the right to request an amendment (correction) to your PHI, but we may deny your request for correction, if we determine that the PHI or record that is the subject of the request: i. was not created by us, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;
ii. is not part of your medical or billing records;
iii. is not available for inspection as set forth above; or
iv. is accurate and complete.
To request an amendment, your request must be made in writing and submitted to the practice office manager at your treating location (252) 333-1277. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing.
In any event, any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.

5. Accounting of Disclosures: You have the right to receive an accounting of disclosures of PHI made by us to individuals or entities other than to you, except for disclosures:
i. to carry out treatment, payment and health care operations as provided above;
ii. to persons involved in your care or for other notification purposes as provided by law;
iii. for national security or intelligence purposes as provided by law;
iv. to correctional institutions or law enforcement officials as provided by law; or
v. that occurred prior to April 14, 2003.
6. Copy of Privacy Notice: You have the right to request and receive a paper copy of this notice from us
.

COMPLAINTS

If you believe that your privacy rights have been violated, you should immediately contact the Practice Office Manager at your treating location (252) 333-1277. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of the Department of Health and Human Services.

CONTACT PERSON

If you have any questions or would like further information about this notice, please contact (252) 333-1277.

HIPAA PRIVACY NOTICE

BY SIGNING THIS NOTICE, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Date: _____

Patient Signature: _____

Printed Name of Patient: _____

Parent, Guardian or Legal Representative Signature: _____

Printed Name of Parent, Guardian or Legal Representative: _____

Relationship to Patient: _____

Legal Representative's Authority to Act for Patient (Power of Attorney, Healthcare Surrogate):_____

Comprehensive Rehabilitation
& Pain Specialists, P.C.
Jessica Fuller-Hines, M.D.
Jessica H. Gorr, D.O.
135 Rich Blvd, Elizabeth City, NC 27909
(252) 333-1277

Informed Consent and Agreement for Treatment with Opioid Analgesic Medications

Patient Name _____ DOB: _____Date _____

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your pain management specialist to comply with the law regarding controlled pharmaceuticals. I understand that this Agreement is essential to the trust and confidence necessary in a doctor-patient relationship and that my pain management specialist undertakes to treat me based on this Agreement. (I have agreed to use opioid analgesics (morphine-like medications) as part of my treatment for acute/chronic pain.) I understand that these drugs could be useful, but have a potential for misuse and are therefore closely controlled by the local, state and federal governments. Because my pain management specialist is prescribing such medication to help manage my pain, I agree to the following conditions. I am aware that failure to abide by any of these conditions will be considered a breach of this agreement, and at the sole discretion of my pain management specialist or the medication utilization review committee, may result in the termination of our physician//NP-patient relationship. In this case, my provider will stop prescribing these pain- control medicines. Also, a drug-dependence treatment program may be recommended.

1. I agree to take the medication only as prescribed and to contact my physician before any changes are made. I understand that when taken otherwise, they can cause overdose and death. Initials: _____
2. I will not request or accept a prescription for opioid pain medicines from any other physician or individual while I am receiving such medication from my pain management specialist. Initials: _____
3. If I have side effects that are related to opioid medication. I will tell my doctor immediately. Initials: _____
4. I am also responsible for notifying my pain management specialist immediately if I need to visit another physician or emergency room due to pain. Initials: _____
5. I understand that the opioid medication is strictly for my own use. I will not share, sell or trade my pain medication with anyone. If children are in the house, a childproof top is mandatory. Initials: _____
6. I agree to submit to urine, saliva and/or blood screens at any time as determined by my pain management specialist to detect the use of both prescribed and non-prescribed medication. I may also be requested to bring my medication in at any time for the pain management specialist to inspect. Initials: _____
7. Abuse of our staff cannot and will not be tolerated. Physical and/or verbal abuse, threats, harassment, or excessive annoyance of our staff (including multiple phone calls, i.e. more than three (3) on the same day), regarding the same question or request, will unfortunately necessitate discharging the patient from our practice. If physical threats, verbal threats, or harassment occur, the proper authorities will be notified, and you will be fully prosecuted by the law. Initials: _____
8. If you leave your appointment before the physician or NP has completed the entire visit. That is considered an automatic self-discharge. Initials: _____
9. I will not drink alcohol, use illegal drugs (ex: marijuana, cocaine, heroin, etc.) or take over the counter medications without talking to my doctor. Initials: _____
10. I understand that if I miss 3 scheduled appointments without proper cancellation notice, I may be discharged from the practice. Initials: _____
11. I understand that if I miss my appointment or are more than 10 minutes late your appointment will be rescheduled, I will not receive medication. Initials: _____
12. I should not drive or operate heavy machinery if I feel impaired in any way from any medications, even including over-the-counter medication. I understand this requirement may impede on my daily work functions. Initials: _____

13. I am responsible for keeping track of the amount of medication remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. Lost or stolen medicines will likely not be replaced. Initials: _____

14. I will receive no pain medication from any other doctor except in any emergency. (ER or admitted to hospital) I will notify my doctor right away if treated by the ER. Initials: _____

15. *Prescriptions must be filled* at *the same pharmacy* (as designated below). I will update my record of pharmacy should it change. Initials: _____

16. Pharmacy Name: _____ Phone #: _____

17. Pharmacy Address: _____

18. Refills must be initiated through your pharmacy or the patient portal only. We no longer accept medication refills directly through our offices. Once a prescription has been approved by your provider you will be notified. Prescription pick-ups are during *regular office hours* 9am-12pm and 1pm-4pm, Monday through Thursday, and can be picked up only in person. Refills requested received on Fridays, nights, holidays or on weekends will not be made available until 48-72 business hours. Prescriptions will not be mailed. Initials: _____

19. Refills shall not be made if I "run out early", "lose a prescription" or spill or misplace my medication. Initials: _____

20. Refills shall not be made as an "emergency," such as on Friday afternoon because I suddenly realize I will "run out tomorrow." Make sure to call your pharmacy or send a message through the patient portal at least 72 business hrs. before you run out. Initials: _____

21. I will tell my doctor all of my past medical history including a history of alcoholism, prescription drug abuse, or illegal drug abuse. Initials: _____

22. I will bring my pill in original bottles to each visit. Initials: _____

23. I authorize the release of any information and medical records by the pain management specialist, his or her designee, and my pharmacy to other healthcare providers, pharmacist, my family, my employer, my insurance company or other reimbursing agencies. I also authorize the pain management specialist, his or her designee, and my pharmacy to contact any legal authority, or regulatory agency to obtain or provide information about my care or actions if the pain management specialist feels it is necessary and to cooperate fully with any city, state or federal law enforcement agency, including the North Carolina Board of Pharmacy and Drug Enforcement Administration, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my pain management specialist 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. Initials: _____

24. I will take appropriate steps not to become pregnant while I am in a pain management program. I also understand that if I became pregnant, or if I am suspicious that I am pregnant, I will notify the doctor and staff of the office immediately. I further accept that any medication may cause harm to my embryo/fetus/baby and hold Comprehensive Rehabilitation & Pain Specialists, its shareholders, officers, directors, employees, contractors and agents harmless for injuries to the embryo/fetus/baby. Initials: _____

25. I hope opioid medications may reduce my pain, making it easier to: Go back to work, sleep through the night without pain, improve my activities of daily living and improve my mobility. Initials: _____

26. Pain and pain treatment are different for each person. Opioid medications are a type of pain reliever medicine used to reduce moderate to severe pain. Opioid medications can reduce some (but not all) types of pain. It is not known how much improvement in pain, activity and quality of life I may have by using these medicines. My clinician will routinely check how I am doing to determine whether the benefits of opioid medicines outweigh the side effects and risk of continuing to use them. Initials: _____

27. I understand that opioid medications can cause physical dependence, tolerance, addition and other side effects. Common side effects include lowered testosterone levels, infertility, impotence, depression, constipation, breathing problems during sleep and disruption of sleep. Initials: _____

28. I understand that no agreement can anticipate all events in medical treatment which may arise and that me and my heirs, will hold harmless Comprehensive Rehabilitation & Pain Specialists, its shareholders, officers, directors, employees, contractors and agents for all resultant problems. This Agreement supersedes and replaces all previous agreements.

Initials: [redacted]

By signing below, I certify that I have read the above Information, I have received a copy of the contract and all my questions regarding the treatment of pain with opioid analgesic medications have been answered to my satisfaction. I hereby give my consent to participate in opioid medication therapy.

Patient signature: _____ Date: _____

Physician: _____ Date _____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____
Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe) _____

Signature of Privacy Officer _____

PLEASE COMPLETE ALL SECTIONS

Comprehensive Rehabilitation & Pain Specialists, P.C.

Jessica Fuller-Hines, M.D.
Jessica H. Gorr, D.O.

135 Rich Blvd, Elizabeth City, NC 27909
(252) 333-1277

PAIN QUESTIONAIRE

Name: _____ Age: _____ Gender: _____ Date: _____

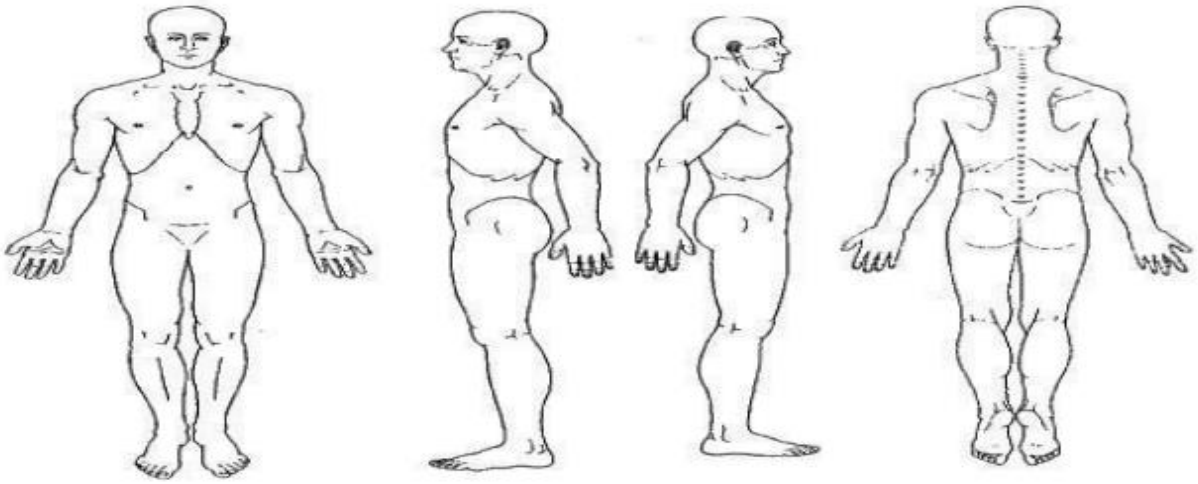
Where is your worst pain? _____

How did the pain start? _____

_____

_____

Please mark the diagram: P=Pain, B=Burning, T=Tingling, N=Numbness, W=Weakness



Pain Scale: (Circle the number that represents your current level of pain.)

NO PAIN **UNBEARABLE**

0 1 2 3 4 5 6 7 8 9 10

Circle the best response(s) for the following questions

When is your pain at the worst? MORNING AFTERNOON EVENING

When is your pain at its best? MORNING AFTERNOON EVENING

Is your pain? CONSTANT FREQUENT INTERMITTENT OCCASIONAL

How would you describe your pain? Sharp Aching Burning throbbing Shooting Electric like Indescribable Other _____

PLEASE COMPLETE ALL SECTIONS

What worsens your pain? Standing Walking Sitting Activity Bending Twisting Lying down Other _____

What relieves your pain? Medication Sitting Lying down Standing Physical Therapy

Chiropractic Manipulation Heat Ice Other _____

Does your pain affect any of the following? Concentration Work Duties Activities of Daily Living Physical Activity Appetite Sleep Other_____

Have you ever been to a pain management clinic in the past for your complaint? Yes No

If yes, when and where and who did you see? _____

_____

Please identify which of the following pain medications have been tried on the past by checking the appropriate box**. (Do not check any drug never taken)**

	Helpful?			Helpful?			Helpful?	
NSAIDs	**Y**	**N**	**Muscle Relaxants**	**Y**	**N**	**Anticonvulsants**	**Y**	**N**
Motrin			Skelaxin			Neurontin		
Lodine			Norflex			Lamictal		
Naprosyn			Soma			Topomax		
Relafen			Robaxin			Depakote		
Indocin			Flexeril			Tegretal		
Celebrex			Zanaflex			Dilantin		
Mobic			Valium			Lyrica		
Opioid **(Narcotic)**			**Others**			**Antidepressant**		
Darvocet			Stadol			Elavil		
Percocet			Talwin			Pamelor		
Lortab/Vicodin			Fioricet			Doxepin		
Norco			Ultram (tramadol)			Tofranil		
Duragesic			Zostrix			Desyrel		
Dilaudid			Ketamine			Welbutrin		
Oxycontin			Lidoderm			Anafranil		
MS Contin			Imitrex			Luvox		
MS IR			Amerge			Zoloft		
Kadian			DHEA			Remeron		
Levorphanol			Guiafensin			Paxil		
Methadone			Dextromethorphan			Prozac		
Atiq			Steroids			Serzone		
Opana			Suboxone			Effexor		
Exalgo						Risperadol		
Butrans						Zyprexa		
Nucynta						Cymbalta		
						Savella		

PLEASE COMPLETE ALL SECTIONS

Please identify the previous pain treatments you have tried in the past, and indicate if they were helpful.

Helpful?

Treatment/Procedure	Y	N	Please Explain	Date of last visit/procedure
Physical/Occupational therapy				
Orthotic Device				
TENS unit				
Osteopathic Manipulation				
Epidural Injection				
Facet Block				
Nerve block				
Sacroiliac Joint Injection				
Trigger Point Injection				
Joint injection				
Acupuncture				
Chiropractor				
Stimulator/Pump				
Massage Therapy				

Past Medical History

Please indicate any current or past medical conditions you have been treated for

Cardiac	Y	N	**Pulmonary**	Y	N
Hypertension			Smoker		
Hypercholesterolemia			Asthma		
Coronary Artery Disease/MI			COPD/Emphysema		
Irregular Heart Beat			Sleep Apnea		
Atrial fibrillation/flutter			Lung Cancer		
Internal cardiac defibrillation/pacemaker			**Endocrine**		
Peripheral vascular disease			Diabetes		
Other:			Diabetic Peripheral Neuropathy		
Gastrointestional			Grave's Disease		
GERD			Hypothyroid		
Gastritis			Other:		
Gastric Ulcer			**Musculoskeletal**		
Irritable bowel disease			Osteoarthritis		
Hepatitis			Rheumatoid Arthritis		
Liver cirrhosis			Sjogren's disease		
Other:			Degenerative joint disease		
Renal			Fibromyalgia		
Renal insufficiency			Lyme's Disease		
Renal Failure			Other:		
Kidney Stones					
Other:					
Neurological			**Psychiatric**		
Stroke			Depression		

PLEASE COMPLETE ALL SECTIONS

TIA			Anxiety			
Migraines			Bipolar			
Seizure Disorder			Schizophrenia			
Multiple Sclerosis			Panic Disorder			
Alzheimer's Disease			Post-Traumatic Stress Disorder			
Dementia			History of alcohol/drug abuse			
Other:			Other:			
Hematological						
Anemia			Low platelets			
Bleeding disorder			Blood clots			
Leukemia			Lymphoma			
Other:			Other:			

Surgical History

Date	Surgery	Date	Surgery

Social History

Circle all that apply

Do you currently smoke tobacco? YES NO If Yes: How many packs per day? _____

How many years? _____ If ex-smoker: when did you quit? _____

Do you currently drink alcohol? YES NO If Yes: BEER LIQUOR WINE

Amount per day? _____ Amount per week? _____

Do you currently use any illicit drugs? YES NO If Yes: What do you use? _____

Currently working? YES NO FULL-TIME PART-TIME RETIRED
DISABLED Occupation/Former occupation? _____

Family History

Check all that apply

	Hypertension	Diabetes	Heart Disease	Cancer (what type?)	Lung Disease	Other
Mother						
Father						
Siblings						
Grandparents						
Aunts/Uncles						

PLEASE COMPLETE ALL SECTIONS

Current Medications

Medication	Dose/Frequency	Medication	Dose/Frequency

Are you currently taking any of the following anticoagulants (circle all that apply)?

Aspirin Coumadin Plavix Aggrenox Xarelto Pradaxa Eliquis Lovenox

Allergies/Intolerances

Medication	Reaction

Imaging/Studies with dates and location

Type of study	Date	Location
MRI		
CT Scan		
X-ray		
EMG		
Other		

PLEASE COMPLETE ALL SECTIONS

Review of Systems

Have you recently had any of the following problems or symptoms (in the past 3-6 months)? (circle all that apply)

Constitutional

Chills	Decline in Health	Fatigue
Fever	weakness	Weight gain
Weight loss		

Head

Dizziness	Fainting	Head Injury
Headaches	Pain	Sweats

Eyes

Blurry vision	Cataracts	Discharge
Double Vision	Excessive tearing	Eye Pain
Eyeglass Use	Glaucoma	Infections
Pain with Light	Recent Injury	Redness
Unusual sensations	Vision Loss	

Nose

Discharge	Frequent Colds	Hay Fever
Infections	Nasal Obstruction	Nosebleeds
Sinus Infections		

Mouth

Bleeding gums	Change in Dentition	Hoarseness
Postnasal drip	Tongue Burning	Voice Changes

Ears

Discharge	Dizziness	Hearing Aid
Hearing Impairment	Infections	Pain
Ringing in Ears		

Throat/Neck

Frequent Sore Throats	Lumps	Tenderness
Tonsils Enlarged		

Respiratory

Asthma	Cough	Wheezing
Bronchitis	Coughing Blood	Pain
Pleurisy	Positive TB Test	Recent X-ray
Short of Breath	Sputum	Tuberculosis

Cardiovascular

Chest Pain	Palpatations	Varicose Veins
Extremity(s)	Extremity(s) Discolored	Hair Loss on Legs
	Heart Tests (Not EKG)	High Blood Pressure

PLEASE COMPLETE ALL SECTIONS

Heart Murmur
History of Heart Attack
Rheumatic Fever
Short of Breath-Sleeping
Ulcers on Legs
Leg Pain-Walking
Short of Breath-Exertion
Swelling of Legs
Recent Electrocardiogram
Short of Breath-Lying Flat
Thrombophlebitis

Gastrointestional
Abdominal Pain
Heartburn
Rectal Bleeding
Black Tarry Stools
Change in Stool Color
Excessive Hunger
Hemorrhoids
Laxative Use
Swallowing Problem
Constipation
Jaundice
Abdominal X-ray Tests
Change in Frequency of BM
Change in Stool Consistency
Excessive Thirst
Hepatitis
Nausea
Vomiting
Diarrhea
Liver Disease
Antacid Use
Change in Stool Calibur
Decreased Appetite
Gallbladder Disease
Infections
Rectal Pain
Vomiting Blood

Musculoskeletal
Arthritis
Back Problem
Muscle Cramps
Restricted Motion
Joint Pain
Deformities
Muscle Stiffness
Weakness
Gout
Joint Stiffness
Paralysis

Psychiatric
Depression
Disturbing Thoughts
Memory Loss
Psychiatric Disorders
Behavioral Change
Excessive Stress
Mood Changes
Disorientation
Hallucinations
Nervousness

Breasts
Discharge
Self-examination
Lumps
Tenderness
Pain

Skin
Eczema
Easy Bruisability
Hives
Nail Appearance Change
Skin Color Change
Itching
Hair Dye
Lumps
Nail Texture Change
Dryness
Hair Texture Change
Mole Increased Size
Rashes

Neurological
Loss of Consciousness
Dizziness
Headaches
Paralysis
Tingling
Blackouts
Fainting
Memory Loss
Speech Disorders
Tremors
Burning
Head Injury
Numbness
Strokes
Unsteady Gait

PLEASE COMPLETE ALL SECTIONS

Endocrine
Weakness
Cold Intolerance
Goiter
Neck Pain
Weight Gain
Excessive Urination
Heat Intolerance
Sweats
Weight Loss
Fatigue
Increased Thirst
Thyroid Trouble

Hematologic/Lymph
Anemia
Easy Bruisability
Swollen Glands
Bleeding Easily
Lumps
Transfusion Reaction
Blood Clots
Radiation Exposure

Allergic/Immunologic
Coughing
Itchy Eyes
Runny Nose
Watery Eyes
Coughing with Exercise
Itchy Nose
Sneezing
Wheezing
Hives
Recurrent Infections
Stuffy Nose
Wheezing with Exercise

Urinary
Awakening to Urinate
Burning
Flank Pain
Infections
Stones
Urine Odor
Bed-Wetting
Difficulty Starting Stream
Frequency
Pain on Urination
Urgency
Blood in Urine
Excessive Urination
Incontinence
Retention
Urine Discoloration

Male Genitalia
Discharge
Impotence
Prostate Problems
Venereal Disease
Fertility Problems
Lesions
Scrotal Masses
Hernias
Pain
Sexual Problems

Female Genitalia
Birth Control
Change in Periods-Flow
Difficult Pregnancy
Hernias
Menopause
Postmenopausal Bleeding
Sexual Problems
Bleeding Between Periods
Change in Periods-Interval
Discharge
Itching
Menstrual Pain
Recent Pap Smear
Venereal Disease
Change in Periods-Duration
DES Exposure
Fertility Problems
Lesions
Pain on Intercourse
Current or Recent Pregnancy

SOAPP® Version 1.0-14Q

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
6. How often have you attended an AA or NA meeting?	0 1 2 3 4
7. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
9. How often have your medications been lost or stolen?	0 1 2 3 4
10. How often have others expressed concern over your use of medication?	0 1 2 3 4

 The SOAPP® was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PainEDU.org
IMPROVING PAIN TREATMENT THROUGH EDUCATION

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

11. How often have you felt a craving for medication?	0 1 2 3 4
12. How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
14. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.