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medical pain clinic

Welcome to Realief Medical Pain Clinic,

We are a fragrance free clinic. We are looking forward to meeting you at your appointment**. Please arrive 15 minutes earlier for the check in process.**

Your appointment is scheduled for: _____

Dr. Anderson and his team are dedicated to providing you with quality pain management care, paying attention to your personal needs. The office staff is here to further assist you in any way. Please read this letter to help enhance your visit with us.

Enclosed in this document are several policies and forms. **Please have the paperwork filled out and completed prior to your appointment. If you do not have them with you and completed, your appointment will be rescheduled.** In your packet you will find:

- HIPAA Notice of Privacy and Acknowledgement Form: this advises you of your privacy rights and states you have received HIPAA information

- Medical History From and Health Status Questionnaire: please fill this out completely, this gives Dr. Anderson and his team the information they need to treat you.

- If your injury is due to a **Motor Vehicle Accident**: Medical History From, Motor Vehicle Accident Form, and Health Status Questionnaire. This gives the Doctor information on your medical history and your motor vehicle accident.

- Payment Form: Please read this form carefully. Realief Medical, P.A. is not a provider for any HMO or PPO's, so we are out of network for most patients. We will bill your insurance company for you but there are some insurance providers, such as BCBS, who will not pay an out-of-network provider directly; therefore those patients will be required to pay for service on the day of the office visit. **Also, as an out of network provider for all HMO or PPO, patients are required to pay in full at the time of the first appointment. This should have been explained to you when you scheduled your consultation.**

- **Patients are responsible for any amount that their insurance does not cover. NO exceptions will be made to this policy. Patients that have Minnesota Medical Assistance or Minnesota Care through an HMO will have to sign a waiver and pay at time of service as we are not a provider for any HMO or PPO.**

- Release of Information Form; this allows us to release your medical records to your insurance company and/or other designated Persons and allows us to request records from your other Doctors and medical providers.

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- Prior to Your Appointment
- Complete the enclosed forms. Please *sign and date* in all required areas, as these forms are legal documents.
- Check with your insurance to find out if you need a referral from your primary care physician.
- Have pre approval from your Work Comp adjuster prior to coming for your appointment or plan on paying at the time of your appointment.

The Day of Your Appointment

- Please bring any medication that you are currently taking with you. Include a list of all herbs, supplements, and over the counter medication.
- Bring your current medical insurance card(s) with you.
- Valid driver's license or photo identification card.

Please call us if you have any questions prior to your appointment.

Thank you for choosing Realief Medical, P.A.

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Patient Information

Full name: _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Date of Birth: _____/_____/_____ **Age**: _____ **Social Security #:** _____

(Circle One) Chronic Pain Injury Accident

Date of onset: _____/_____/_____

(Circle One) Right handed Left hand

Marital status (circle one) Married Single Separated Divorced Widowed

Name of spouse or partner: _____

Spouse or partner's phone number: _____-_____-_____

Motor Vehicle Accident

(If this is not due to a motor vehicle accident, do not fill out)

Date of accident: _____/_____/_____

Auto insurer: _____

Address: _____

Name of policy holder: _____

Policy number: _____

Claim number: _____

Adjuster's name: _____

Adjuster's phone number: _____-_____-_____

If you are not on the policy, what is your relationship to the policy holder? _____

What is the make and model or your vehicle? _____

Location of accident: _____

_____

Was there another vehicle involved? Yes / No

How did your accident happen?

_____

_____

_____

Do you have an attorney representing you for this injury? Yes / No

Name of Attorney: _____

Firm name: _____

Address: _____

Phone number: _____-_____-_____

Chief Complaints

List the pain and other symptoms you have in order of importance to you:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

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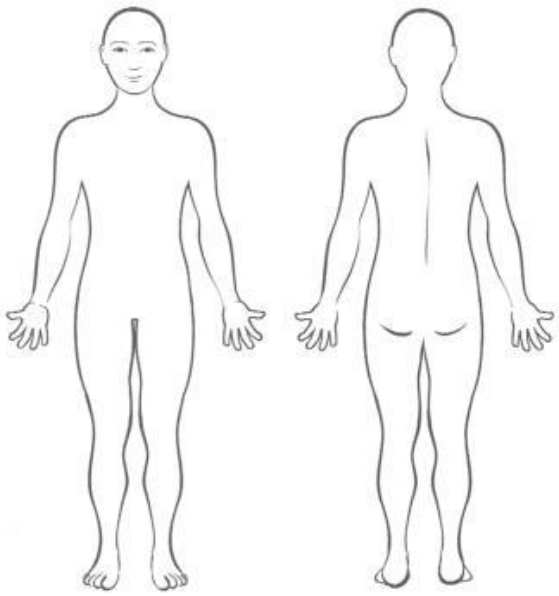
Severity of symptoms

Draw in the areas of pain or other symptoms:

Also, please grade the intensity of pain in the areas below using 0-10 with 0 being no pain and 10 being the worst imaginable pain.



Circle of the words that describe your pain symptoms:

Aching	Dull	Tender	Cramping
Pressing	Pinching	Pulsing	Prickling
Electric	Sharp	Crushing	Stabbing
Tightness	Throbbing	Knot like	Gnawing
Burning	Pounding	Shooting	Other: _____

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Variation of Pain

How frequent do you experience pain? (Circle the one that applies to you)

Constant _____X per day _____X per week _____ X per month _____X per year

How long does this pain last at a time? Never stops _____Min _____Hrs. _____Days

What time of day does your pain typically occur? _____ AM _____ PM _____ All day

What time of the day does your pain most likely occur?

Morning Afternoon Evening Night Unpredictable

Do you experience headaches? Yes or No **(If yes circle the one that applies best to you below)**

Constant _____X per day _____X per week _____ X per month _____X per year

With the headaches do you also experience?

Neck pain Nausea Light or Noise Sensitivity Vomiting Extreme Fatigue

What seems to improve your symptoms? _____

_____

What seems to aggravate your symptoms? _____

_____

Describe how your symptoms have changed since they started: _____

_____

_____

_____

List things that you can no longer do because of your pain symptoms: _____

_____

How long can you perform these activities before your pain stops you from continuing?

Sit: _____hour(s) _____min(s) Stand:_____hour(s) _____min(s) Walk:_____hour(s)_____min(s)

Current/Past Medications (attach addition information sheet if needed)

List your current medications/nutritional supplements and dosages: _____

_____

_____

Past medications tried for treatment of condition: _____

_____

_____

Allergies/Drug Reactions

Do you have any allergies/drug reactions to medications? **Yes or No**

If yes, please list: _____

_____

_____

Current Immunizations: _____

Previous Trauma/Hospitalizations

Have you had any previous trauma: Yes / No

Where: At home / at work / auto / other: _____

Describe trauma and treatment: _____

_____

_____

Any previous surgeries/hospitalizations: Yes / No

If yes, please describe: _____

_____

_____

Other Healthcare (attach addition information sheet if needed)

List all your healthcare provider's that you have seen for this injury/illness: _____

_____

_____

_____

Changes in Social History

Have you notices any change in memory or concentration since your date of injury/illness? _____

_____

Circle the words that describe how you have been feeling lately:

Depressed Irritable Unmotivated Sad Tearful Angry Tired Anxious Distracted Loved Supported

Have you been having any difficulty reading since your injury/illness? _____

_____

School/Employment information

Did you complete high school? Yes / No

Additional education: _____

Employer: _____

Employer's address: _____

Occupation: _____

Is heavy lifting a part of your job? **Yes / No**

If yes, please describe:_____

Is repetitive motion a part of your job? Yes / No

If yes, please describe:_____

Have you ever been off work as a result of your injury/illness? Yes / No

If yes, please describe:_____

History

In the last year have you used:

Marijuana Cocaine Heroin Crack Methamphetamine LSD PCP

Do you have a history of chemical abuse? Yes / No

Alcohol Intake:

Never ____Yearly ____ Monthly ____ per day ____ per week ____ Socially ____Medicinal

Does alcoholism run in your family? _____

Have you ever had a DWI? Yes / No

If yes, when: _____

Tobacco Intake:

None Chewing Tobacco Smoke: _____ #of cigarettes per day _____# of cigars per day

Would you like to quit? Yes or No

Health Conditions that started before or after the injury/chronic illness:

Before **After** **Before** **After**

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◯	◯	Headaches		◯	◯	High blood pressure	
◯	◯	Neck pain		◯	◯	Heart attack	
◯	◯	Upper back pain		◯	◯	Chest pains	
◯	◯	Middle back pain		◯	◯	Stroke	
◯	◯	Lower back pain		◯	◯	Lung problems	
◯	◯	Shoulder pain		◯	◯	Kidney stones	
◯	◯	Elbow/arm pain		◯	◯	Kidney disorder	
◯	◯	Wrist pain		◯	◯	Bladder infection	
◯	◯	Hand pain		◯	◯	Painful urination	
◯	◯	Hip/upper leg pain		◯	◯	Loss of bowel control	

Before	**After**		**Before**	**After**	
◯	◯	Knee/lower leg pain	◯	◯	Prostate problems
◯	◯	Ankle/foot pain	◯	◯	Abnormal weight loss/ gain
◯	◯	Jaw pain	◯	◯	Loss of appetite
◯	◯	Joint swelling/stiffness	◯	◯	Abdominal pain
◯	◯	Osteoarthritis	◯	◯	Ulcer
◯	◯	Rheumatoid arthritis	◯	◯	Hepatitis A B C
◯	◯	Chronic fatigue	◯	◯	Liver/gallbladder disorder
◯	◯	Muscular incoordination	◯	◯	Cancer/tumor
◯	◯	Visual disturbances	◯	◯	Asthma
◯	◯	Dizziness	◯	◯	Chronic sinusitis

◯	◯	Allergies		◯	◯	Smoking/use of tobacco products	
◯	◯	Drug/alcohol addiction		◯	◯	Diabetes	
◯	◯	Excessive thirst		◯	◯	Thyroid disorder	
◯	◯	Frequent urination		◯	◯	Depression	
◯	◯	Systemic lupus		◯	◯	Epilepsy	
◯	◯	Loss of consciousness		◯	◯	HIV/AIDS	
◯	◯	STD: _____					

Females Only:

◯	◯	Birth control pills/Depo
◯	◯	Hormone replacement therapy
◯	◯	Pregnancy

Indicate if any immediate family member has had any of the following:

◯ Rheumatoid arthritis ◯ Heart problem ◯ Diabetes ◯ Cancer ◯ Lupus ◯ Chronic Pain ◯ Migraines ◯ Other

_____

I, _____ consent that all of the answers to this questionnaire are accurate to my knowledge.

Signature: _____ Date: _____/_____/_____

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SOAPP-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no wrong or right answers.

	Never	Seldom	Sometimes	Often	Very Often
1. How often are do you have mood swings?	◯	◯	◯	◯	◯
2. How often have you felt a need a stronger medication to treat your pain?	◯	◯	◯	◯	◯
3. How often have you felt impatient with your doctors?	◯	◯	◯	◯	◯
4. How often have you felt that things are just too overwhelming that you can't handle them?	◯	◯	◯	◯	◯
5. How often is there tension at home?	◯	◯	◯	◯	◯
6. How often have you counted pain pills to see how many are remaining?	◯	◯	◯	◯	◯
7. How often have you been concerned that people will judge you for taking pain medication?	◯	◯	◯	◯	◯
8. How often do you feel bored?	◯	◯	◯	◯	◯
9. How often have you taken more pain medication than you were supposed to?	◯	◯	◯	◯	◯
10. How often are you worried about being left alone?	◯	◯	◯	◯	◯
11. How often have you felt a craving for medication?	◯	◯	◯	◯	◯
12. How often have others expressed concern over your use of					

medication	○	○	○	○	○
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
	Never	**Seldom**	**Sometimes**	**Often**	**Very Often**
14. How often have others have told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or have been arrested?	○	○	○	○	○
19. How often have you attended AA or NA Meetings?	○	○	○	○	○
20. How often have you been in an argument that was so out of control someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○

	Never	Seldom	Sometimes	Often	Very Often
23. How often have you had to borrow pain medications from your family or friends?	◯	◯	◯	◯	◯
24. How often have you been treated for an alcohol or drug problem?	◯	◯	◯	◯	◯

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

Patient signature: _____ Date: _____/_____/_____

Health Status Questionnaire (HSQ-12)

Patient Name: _____

Instructions:

This survey asks for your views about your health. This information will be summarized in your medical record and will help your doctors keep track of how you feel and how well you are able to do your usual activities.

Answer every question by circling only one answer 1, 2, 3…. If you are unsure about how to answer a question, please give the best answer you can and make a comment in the left margin.

1. In general, would you say your health is: *(Circle one number)*

Excellent…… 1

Very Good…… 2

Good…… 3

Fair…… 4

Poor…… 5

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If yes, how much? *(Circle one number on each line)*

	Limited a lot	Limited a little	Not limited at all	
2. Lifting or carrying groceries……..	1	2	3	0, 50, 100
3. Climbing several flights of stairs……	1	2	3	0, 50, 100
4. Walking several blocks……..	1	2	3	0, 50, 100

5. During the **past 4 weeks,** how much difficulty did you have doing your work or other regular daily activities as a result of your physical health *(Circle one number)*

None at all……..1 100

A little bit…… 2 65

Moderately…….. 3 25

Quite a bit…….. 4 10

Couldn't do any work…….. 5 0

6. During the **past 4 weeks,** to what extent have you accomplished less than you would like in your work or other daily activities **as a result of emotional problems** (such as feeling depressed or anxious)? *(Circle one number)*

None at all…….. 1 100

A little bit…….. 2 65

Moderately…….. 3 45

Quite a bit…….. 4 20

Extremely…….. 5 0

7. During the **past 4 weeks,** to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? *(Circle one number)*

None at all…….. 1 100

A little bit…….. 2 75

Moderately…….. 3 50

Quite a bit…….. 4 25

Extremely…….. 5 0

8. How much bodily pain have you had during the **past 4 weeks?** *(Circle one number)*

None…….. 1	100
Very Mild…… 2	85
Mild…….. 3	60
Moderate…… 4	45
Severe……. 5	25
Very Severe…… 6	0

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the **past 4 weeks….**

9. Have you felt calm and peaceful? 100, 80, 60, 40, 20, 0

All of the time ……. 1

Most of the time…… 2

A good bit of the time…… 3

Some of the time…….. 4

Little of the time…… 5

None of the time…… 6

10. Did you have a lot of energy? 100, 80, 60, 40, 20, 0

All of the time ……. 1

Most of the time…….. 2

A good bit of the time…….. 3

Some of the time…… 4

Little of the time…….. 5

None of the time…… 6

11. Have you felt downhearted or blue? 100, 80, 60, 40, 20, 0

All of the time ……. 1

Most of the time …… 2

A good bit of the time…….. 3

Some of the time…….. 4

Little of the time…….. 5

None of the time…….. 6

12. Have you been happy?

All of the time ……. 1 100, 80, 60, 40, 20, 0

Most of the time…….. 2

A good bit of the time…….. 3

Some of the time…… 4

Little of the time…….. 5

None of the time…… 6

Please answer YES or NO for each question by circling “Y” or “N” on each line.

13.	In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed?	**Y**	**or**	**N**
14.	Have you had 2 years or more in your life when you felt depressed or sad?	**Y**	**or**	**N**
15.	Have you felt depressed or sad as much of the time in the past year?	**Y**	**or**	**N**

Patient signature: _____ Date: _____/_____/_____

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Fibromyalgia Questionnaire

(Circle the best answer that applies)

1. I have pain all over my body Y or N
2. My pain is accompanied by fatigue Y or N
3. My pain is burning, electric or cramping Y or N
4. I have other health issues: Y or N
    - Digestive problems Y or N
    - Urinary problems Y or N
    - Headaches Y or N
    - Restless leg syndrome Y or N
5. Pain involves needles, tingling and numbness Y or N
6. My pain is a significant influence in my life Y or N
7. My pain interferes with concentration Y or N
8. My pain interferes with my sleep Y or N

Signed: _____ Date: _____

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AUTHORIZATION TO RELEASE OF MEDICAL INFORMATION

Thank you for choosing Realief Medical, P.A. as your medical pain management provider. We strive to provide the best medical care possible. This form, as well as the other forms that are enclosed, have been carefully prepared to assist in that care. Please fill them out as thoroughly as you can. If you have a problem completing your forms, please come in for your appointment 15 minutes early and our team will assist you.

Release of Information

I authorize Realief Medical, P.A. and attending physicians to release any and all information to all treating doctors and third party payers. I authorize any and all hospitals, physicians, clinics, and emergency facilities where I have received medical treatment to release any and all medical information to Realief Medical, P.A. I agree that a photocopy of this form is as valid as the original and is valid for the duration of my claim.

Assignment of Benefits

I authorize all insurance benefits to be paid directly to Realief Medical, P.A. I authorize the release of all necessary information to file and complete all insurance claims.

Financial Policy

Services: Payment is due at the time of service unless otherwise agreed upon by Realief Medical, P.A. Realief Medical, P.A. is not a participating provider for managed care programs (HMO or PPO). Realief Medical, P.A. is not a provider for Minnesota Care or many Minnesota Medicaid insurances so Realief Medical, P.A. cannot always file an insurance claim. Payment will be collected prior to your appointment. Realief Medical, P.A. does not bill Workers' Compensation secondary providers unless there is a pre authorization received. **Any unpaid debt is cause for Realief Medical, P.A. to refuse to provide care.**

Payments: Realief Medical, P.A. accepts cash, personal checks, Visa, Master Card, and Discover for payment of any and all services. We will bill your health insurance or accept payment at time of service.

Insurance: Your insurance is a contract between you and your insurance company. **WE MUST EMPHASIZE THAT AS YOUR MEDICAL PROVIDER, OUR RELATIONSHIP IS WITH YOU, NOT YOUR INSURANCE COMPANY.** While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. It is the responsibility of the patient or guarantor to present a valid insurance card or claim information each and every time that you are seen, before covered services are rendered. If, for any reason your insurance claim is denied or not paid in full you are responsible for payment.

THE USE OF EXPIRED OR FRAUDULENT INSURANCE CARDS OR CLAIM INFORMATION MAY CONSITITUTE FRAUD RESULTING IN BOTH CRIMINAL AND CIVIL COURT ACTION. INSURANCE DENIALS THAT ARE RECEIVED BY MEDICAL PAIN MANAGEMENT NEED TO BE ADDRESSED IMMEDIATELY UPON NOTICE TO PATIENT. IF YOUR BILL IS REFERRED FOR COLLECTION TO A COLLECTION COMPANY YOU ARE RESPONSIBLE FOR ALL COLLECTION COSTS INCLUDING COURT AND ATTORNEY FEES. Returned checks are subject to a $25.00 service charge.

If you have any questions regarding any information listed above **PLEASE ASK FOR ASSISTANCE**. We are here to help you. If you would like a copy of this form, please ask the front desk personnel to make a copy of this form for you.

I HAVE READ ALL THE INFORMATION ON THIS DOCUMENT AND BY SIGNING THIS AFFIDAVIT I AM IN AGREEMENT AND I UNDERSTAND AND AGREE TO ALL THAT IT CONTAINS FOR THE DURANTION OF MY CARE.

Patient
Signature_____**Date**_____

(Guarantor/Guardian, if patient is a child under 18)

This document has been read to me by _____, and I understand what it says.
_____ (Initial)

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CONTROLLED MEDICATION AGREEMENT

Patient Name: _____ DOB: _____

I have agreed to use controlled medication as part of my treatment for chronic pain. I understand that these drugs are very useful, but have a potential for misuse and are thereby closely controlled by the local, state and federal governments. MN Prescription Monitoring Program is closely watched. Dr. Anderson and his team will be prescribing such medication to help manage my pain. I agree to the following conditions. I understand that I am being prescribed a controlled medication to improve my level of comfort and therefore improve my function. If my functional level does not improve or declines, then the medication will be changed or discontinued.

***Must be initialed

____***I am aware that failure to abide by any of the conditions listed below will be considered a breach of contract. If this happens all prescriptions will be withdrawn and I will be discharged from all care at Realief Medical, P.A.**

_____***I am responsible for my pain medication.** I agree to be responsible with my medicine. I agree that any lost, stolen, or accidentally destroyed controlled medications or prescriptions will likely not be replaced. This is decided on a case by case review.

____***I will not request or accept controlled medication from any other doctor or individual**.

____***I will see Dr. Anderson on a regular basis.** I will be seen as often as necessary to assess the controlled medication's effectiveness. I understand that this will require a regular scheduled office visit. I may also be told to come in for any changes that come sooner than the appointed visit. I understand that if I do not keep my appointments I may not receive my medication.

_____***I understand that controlled medication prescriptions require a hard copy to be given to pharmacies.** I understand that controlled medication prescriptions will not be called or faxed into pharmacies. Prescriptions can be picked up or mailed directly to the pharmacy after 48 business hours of the refill request. I understand that enough controlled medication will be prescribed to take at the prescribed dose until the next agreed upon clinic appointment.

_____***I will not increase or decrease my dosage without being seen by Dr. Anderson and his team; this is self-medicating and will not be tolerated.** I will take the medication exactly as prescribed and will not increase the dosage and/or frequency without prior approval from Dr. Anderson or his team. Because of the seriousness of the controlled medications, I understand that I may need to be seen at the

clinic for a face to face visit before such changes can be made. I understand that increasing or decreasing my controlled medication without the close supervision of Dr. Anderson and his team could lead to a drug overdose or withdrawal causing severe sedation, respiratory depression, yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot or cold flashes, "goose flesh", abdominal cramps, and diarrhea. These symptoms can occur 24 to 48 hours after the last dose and can last up to three (3) weeks

_____***I understand that I must bring my medication to my clinic visits.** I will bring all of my remaining controlled medications in their prescription bottles as well as any remaining written prescriptions to my appointments with Dr. Anderson and his team. If the dose or type of medication is changed at an appointment, this may require the disposal of the old written/printed prescriptions.

_____***I understand the side effects that are related to controlled medication.** I understand that I may experience some or all of the following side effects from these controlled medications: nausea and vomiting (similar to motion sickness), drowsiness, and severe constipation, mental slowing, flushing, sweating, itching, respiratory depression, urinary difficulty, and jerkiness. Generally, these side effects occur at the beginning of treatment and often go away within a few days. It is my responsibility to notify Dr. Anderson and his team of any side effects that continue or are severe (such as sedation or confusion). I am responsible for notifying Realief Medical, P.A. immediately if I need to visit another physician or emergency room due to side effects or pain.

_____***I will notify Realief Medical, P.A. immediately if I am hospitalized for any reason.**

_____***I will notify my physician if I become pregnant or am trying to become pregnant.**

_____***I understand that the controlled medication is strictly for my own use.** Medication should never be given to others under any circumstances. If children are in the house, a childproof cap is necessary.

_____***I understand that I must contact Dr. Anderson and his team before taking other medication, including over-the-counter medication.** I will contact Dr. Anderson and his team before taking Benzodiazepines (drugs like Valium or Ativan), sedatives (drugs like Ambien, Soma, Xanax, or Fiorinal) and antihistamines (drugs like Benadryl). I understand that the combined use of the above drugs and controlled medications may produce profound sedation, respiratory depression, and even death.

_____***I will not consume alcohol or use recreational drugs while on controlled medication.** If consumed the consequence will be termination of treatment by Dr. Anderson and his team.

_____***I understand that patients with a history of drug or alcohol abuse are at a high risk of relapse from certain medications.** I have notified Dr. Anderson and his team of any personal or family history of substance abuse, including alcohol.

_____***I am responsible for my controlled medication prescriptions.** I understand that refill prescriptions will always be filled at the same pharmacy, shall be made during regular office hours, Monday through Thursday from 8:00am to 4:00pm. Refills will not be made at night, on weekends, or holidays, and will not be replaced or filled early.

_____***I understand that I must submit to random urinalysis.** Using illegal or recreational drugs is dangerous with controlled medications. I will abstain from their use, and if requested I will provide urine and/or blood specimens in order to monitor compliance. I understand my insurance may not cover the cost of the urine test done at Realief Medical, P.A. office and that I am responsible to pay the charge. I understand that these tests will be done at random visits and may also be done before I am started on a controlled medication. I understand that I will not be given any further prescriptions for controlled medication beyond 1 week if I refuse or cannot provide a sample for this test.

_____***I will participate in other treatments.** Since use of controlled medications is only part of my treatment plan, I agree to participate in other treatments that may be recommended. This may include non-medication treatment or consultations with other healthcare providers. I agree to taper or discontinue the controlled medication if other more effective treatments become available.

_____***I authorize the release of information.** I authorize the release of information and records by Realief Medical, P.A. to other healthcare care providers, my spouse, partner, or other family members, my insurance company, or any other third party payer. I also authorize Realief Medical, P.A. to request my records from the facility/physician I have been treated by past or present or from my attorney that is handling my case. I agree that a faxed copy of this form is a valid release of information.

_____***I authorize Realief Medical, P.A. to contact my pharmacist at any time.** I authorize my pharmacist to speak to Dr. Anderson and his team regarding any questions concerning any medications I am receiving/taking.

_____***I understand that it is illegal to carry controlled medication in anything other than the prescription bottle it was filled in.**

_____***I understand that Dr. Anderson will fully cooperate with all law enforcement agencies.** If I violate this contract, Dr. Anderson and his team must consider that I may be abusing or selling medications. Dr. Anderson and his team will report such activities to the appropriate law enforcement

agencies. In this instance, doctor-patient confidentiality does not prevent doctors from providing pertinent information to law enforcement agencies.

_____*I understand that I must follow all of the above policies or be subjected to dismissal of care by Dr. Anderson and his team.**

_____*I understand that there could be a potential legal risk when driving or operating machinery while using an Opioid and/or any controlled medication.**

Note: ***Minnesota Statute 169A.20 states that Minnesota has a zero tolerance DUI offense if a person tests positive for schedule I & II controlled substances. Copy of statue is available upon request.***

_____I am aware that failure to abide by any of the conditions listed in this contract will be considered a breach of contract. If this happens I will have all prescriptions withdrawn and I will be discharged from all care at Realief Medical, P.A. per Dr Anderson's' discretion.***

Please list the full name and contact information of anyone you authorize to pick up prescriptions on your behalf:

***Name*_____**

***Contact Information*_____**

***Name*_____**

***Contact Information*_____**

Pharmacy Information:

Pharmacy Name:_____

Pharmacy Address: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____

All of my questions regarding the above requirements were answered to my satisfaction and now I understand all the requirements above. I agree to them and understand that violation of any of them

will result in termination of the controlled medication. I understand that if a statement was not initialed by me but I signed below I am still bond to all contract requirements. I understand that in order to achieve the purpose of this agreement, all patients under this agreement will be required to follow it without exception.

I hereby give my consent to participate in controlled medication therapy.

Patient's signature: _____
Date:_____

Physicians signature: _____

Date: _____

Witness signature: _____
Date:_____

realief
medical pain clinic

HIPAA NOTICE OF PRIVACY PRACTICES

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of your care at Realief Medical, P.A. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information. We make every effort to insure that your privacy and personal medical information is protected as regulated under both HIPAA and Minnesota state laws.

YOUR RIGHTS

You have the right to request restrictions. You can request in writing restrictions on the way we handle your personal health information for treatment, payment or health care operations. The law does not require us to agree with these restrictions. A written determination will be sent to you.

You have the right to confidential communications. We will make every effort to accommodate reasonable requests to communicate with you about your health information at an alternative location. We must have a current address and telephone number on file. It is important that you understand that bills will be sent to you at the address in your records.

You have the right to access. You have the right to receive, by written request, a copy of your personal health information that is contained in a "designated record set", with some specified exceptions. For example, if your doctor determines that your records are sensitive, we may not give you access to your records. A "designated record set" includes insurance and payment information and case or medical management records.

You have the right to amendment your health information. The Doctor will review this request with you and amend your file accordingly. Records that cannot be amended are records we did not create, records that are accurate and complete, and records complied in anticipation of a civil, criminal or administrative action or proceeding. If we deny your request to amend your records you do have the right to file a written statement of disagreement with us, and we have the right to rebut that statement.

You have the right to share information. With you written approval we will share your personal health information with other people, facilities, or companies.

You have the right to information about certain disclosures. You have the right to request in writing information about the times we have disclosed your personal health information for any purpose other than the following exceptions:

- Treatment, payment, or health care operations.
- Disclosures that you or your personal representative have authorized.
- Certain other disclosures, such as disclosures for national security purposes.
- ***This applies only to disclosures made on or after April 14, 2003.

Other contact information is:

Minnesota Department of Commerce

651-296-2488 or 1-800-657-3602

Signature: _____

Date: _____

Copy to Patient: Accepted Declined

Witness: _____

Realief Medical, P.A. HIPAA Notice of Privacy Practices November 2015