Alabama Anesthesiology & Pain Consultants

Patient Demographic Form

Title: ___Mr. ___Mrs. ___Ms. Full Name: ___________________________

Sex: ___M ___F Date of Birth: ___________________ SS# ___________________

Marital Status: ___S ___M ___D ___W Other: ___________________

Race: ______________ Preferred Language: ______________ Nationality: ______________

Street Address: ___________________________

City: ______________ State: ______________ Zip: ______________

Is your mailing address the same as your physical address? ___Yes ___No.... if different, list below:

Mailing Address: ______________ City: ______________ ST: ______ Zip: ______

Please list Contact Information, it is YOUR responsibility to notify us immediately of changes!

Home Phone: ______________ Cell Phone: ______________

Email Address: ___________________________

MAY WE LEAVE MESSAGES FOR YOU? ___YES ___NO

DO YOU RECEIVE TEXT AT CELL NUMBER ___YES ___NO

**Emergency Contact: ______________ Relationship: ______________

Primary Phone: ______________ Secondary: ______________

What physician referred you to us? ______________ Phone: ______________

Reason for referral: ___________________________

Employment Status: ___FT ___PT ___Self Employed ___Retired ___ Military ___Student ___Unemployed

Employer: ______________ Occupation: ______________

Primary Insurance

Insurance name: ___________________________ (as listed on card)

Insurance ID/Policy #: ______________ Group: ______________

*****If policy is not in your name, the following information must be filled out in full*****

Name of Policy Holder: ___________________________ (as listed on card)

Policy Holder DOB: ______________ SS# ______________

Secondary Insurance

Insurance name: ___________________________ (as listed on card)

Insurance ID/Policy #: ______________ Group: ______________

Name of Policy Holder: ___________________________ (as listed on card)

Policy Holder DOB: ______________ SS# ______________

*** IF YOUR INSURANCE REQUIRES IT, YOU ARE RESPONSIBLE FOR MAINTAINING ACTIVE REFERRAL***

SELF-PAY/ UNINSURED / NON-COVERED SERVICES! PLEASE READ AND SIGN:

I understand that I am financially responsible for my bill a the time of service. If I fail to pay any amount due. I will be responsible for all collection fees, court costs, attorney fees, and other incurred charges in the collection of any balance due. I further understand that a fee of 30-50% will be added to my total account balance in accordance with this facility's contract with its collection agency.

SIGNATURE: ___________________________ **DATE:** ______________

INSURED / THIRD PARTY LIABILITY / COVERED SERVICES PLEASE READ AND SIGN

I hereby authorize my insurance benefits to be paid directly to Alabama Anesthesiology & Pain Consultants. I understand that I am responsible for all changes including my added costs incurred due to any effort to collect for services rendered, I realize I am responsible to pay for non-covered services and here-by authorize the release of any pertinent information in order to process my insurance claims.

SIGNATURE: ___________________________ **DATE:** ______________

Patient Name: ______________________________ **DOB:**___________________

It may be necessary to contact you by phone concerning lab results, test results, and/or other medical reasons; therefore, legally, if we cannot reach you we need your permission to leave results with someone else. Please read and complete the following:

Permission is give to Dr. Matthew Bennett to leave your name and number at one of the following locations: Check One: Home:____________ Office: ______________

Permission is given: ___________ / NOT given: ____________ (please check one) to Dr. Matthew Bennett's office to give my lab results, test results, and/or other medical information to the following: (please list)

Relationship	Name	Phone Number
Spouse	______________________________	__________________
_____________	______________________________	__________________
_____________	______________________________	__________________
_____________	______________________________	__________________

Other Form of Contact	Please enter information below if you wish to be contacted this way
Voicemail / Answering Machine at home	__________________________
Voicemail / Answering Machine at work	__________________________
Email Address	__________________________

Patient Signature: ______________________________ **Date:** _________________

Patient Name:

Past Medical History: (Please list any medical problems that you currently have or have had in the past.) Also, list all medical problems for which you take medications.

____Heart Disease
____Previous Hearth Attack
____Congestive Heart Failure
____High Blood Pressure
____Diabetes Mellitus
___Insulin controlled
___Medicine controlled
___Diet Controlled
____Previous Stroke
____Sleep Apnea
____Chronic Bronchitis
____Asthma
____Cirrhosis

____Seasonal Allergies
____Cancer
Type____________
____Arthritis
_____Osteoarthritis
____MRSA
____Gout
____Seizure Disorder
____Renal Failure (ESRD)
____Kidney Stones
____Depression
____Hypothyroidism

____Heartburn (GERD)
____Stomach Ulcers
____High Cholesterol &/or Triglycerides
____Chronic Constipation
____Migraine Headaches
____Anemia
____Mitral Valve Prolapse
____Fibromyalgia
____Other:
____
____
____

Do you have any hardware in your body? *(stimulator, Pacemaker, Rods, Screws, etc?)*

Past Surgical History: (Please list all surgeries that have been performed throughout your entire life, please include any pain blocks)

Type of Procedure	Hospital	Year performed	Surgeon

Allergies: (Please list all medications that you are allergic to or not able to take including the outcome/reaction)

Medication/Item	Reaction Involved (i.e. rash, swelling, difficulty breathing, etc):

Current Medications: (Please list all medications that you are currently taking, including over-the-counter medications and herbal medications)

Name of Medicine	Strength (i.e. Mg, mcg, g, etc)	How often per day

Social History:

Occupation: (What type of work do you do for a living) ____________________
Does your occupation present hazardous exposures? ___ Yes___No if so What?____________________
Martial Status: ____Single ____Married ____Divorced ____Widowed ____Seperated ____Life Partner
Number of children: _____
What is your exercise routine? ____________________
What is your diet routine? ____________________
Do you use tobacco products: ____Yes ____No If yes, what type?____________________
How much per day?_________________ How many years? ____________________
If you do not currently use tobacco products, did you use them in the past? _____Yes ____No
Year you quit? ________ How much per day? _______________ How many years? ______________
Do you drink alcohol? ____Yes ____No How many drinks per day? _____ per week? ______________
Is abuse a concern? ____________________
Do you currently or have you ever used recreational or "street" drugs? ___ Yes ___No ____Currently ___Past
If so, what type?____________________Last use?______________
Is there a history of drug/alcohol abuse for you? ____Yes ____No Family history of abuse? ___Yes ___No

Family History: (Please list any medical problems that exist in your blood relatives, such as mother, father, brother, sister, children, etc)

Medical Problem	Relationship to you:

NOTICE OF PRIVACY PRACTICES AND YOUR RIGHTS

Following is a statement of your rights to your protected health information.

You have the right to inspect and copy of your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions requested and to who you want the restrictions to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of the notice from us, upon request, even if you have agreed to accept this notice alternatively, ie., electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You have the right to object or withdraw as provided in this notice.

Complaints:

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 13, 2003.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with out HIPPA Compliance Officer in person or by phone at our main phone number.

Your signature below is only acknowledgment that you have received this Notice of Our Privacy Practices.

______________________	______________________	________
Patient Name	**Signature**	**Date**

IMPORTANT POLICIES
READ AND SIGN!

MISSED APPOINTMENT POLICY

If you have missed your scheduled monthly appointment you will be scheduled at the next available appointment date which could be up to 2 weeks from your original scheduled appointment. When on these potentially dangerous narcotic medications we MUST see you every month, and definitely not have you run of of medications. We will check pharmacy records, you will be given a urine drug screen (possibly cost to you), you will be called for a pill count, and we may possibly adjust/change your medications. Without a monthly follow up appointment we cannot write these medications at all and you may not be a candidate for outpatient pain management. If more than one appointment is missed, that is grounds for termination from AAAPC, missed urine drug screens and pill counts are automatic termination. These requirements are all based on current laws and regulations and are NON-NEGOTIABLE. We value you as a patient and thank you for your prompt attention to this matter.

MEDICATION CHANGE POLICIY

1- You MUST fill all of the medications written for you by AAAPC. If there is a mistake made, please let us know.

2- You MUST fill all of your medications on the same day at the same pharmacy.

3- You MUST choose one pharmacy and you are required to let us know what pharmacy you use.

4- Your medicine MUST last you until your next scheduled visit for refill with AAAPC. If they run out or are overtaken, it will lead to pill counts, more urine drug screens (with possible cost to you), and dismissal from practice.

PHARMACY POLICY

Please give us the name, address, and phone number of your pharmacy. The pharmacy we put on file is where medication prior authorizations will be sent if required, and/or all electronic prescriptions. If you change pharmacies, it is your responsibility to notify us. Using different/multiple pharmacies can cause many incoviences, including a delay in recieving your mediation on time. We will not disrupt clinic or our care for other patients by not having your correct pharmacy on file.

For anyone requiring a medication prior authorization, we require a 24-48 hour time period to get all required information submitted to your insurance company. Most insurance companies require 24 - 72 hours to process the authorization. Obtaining a prior authorization for medication is a courtesy we offer our patients, not a requirement. It will be authorized for the pharmacy we have on file. Thank you for your understanding and helping us to help you with your health care needs.

PHARMACY: ____

ADDRESS: ____

____

PHONE NUMBER: ____

PHARMCY DRUG COVERAGE: ____________________________________

I, ____, have read and FULLY understand each of these stated policies.

PATIENT: ______________________________ **DOB:** ________________ **DATE:** ____________________

WITNESS: ______________________________________ **DATE:** ____________________________

SAFE USE OF LONG & SHORT-ACTING OPIATES AND CONVERSION OH SHORT TO LONG-ACTGING.

Long-acting opiate pain relievers are medicines used to relieve moderate to severe long-term pain. They are also called extended-release opiates. Opiates relieve pain by changing the way your body feels pain. They do not cure a health problem, but they help you manage the pain.

If you take a lot of short-acting medicine, your doctor may give you long-acting opiates. Long-acting opiates help you avoid the ups and downs in pain relief that you may have with short-acting medicine.

Opiates are powerful medicines. When taken on schedule and as your doctor prescribes, they work well and are safe. But, misuse can cause overdose, dependency, addiction or death.

What is an opiate?

A medication or an illegal drug that is derived from the opium poppy or that mimics the effect of an opiate (a synthetic opiate). Opiate drugs are narcotic sedatives that depress activity of the central nervous system, reduce pain, and induce sleep. Side effects may include over sedation, nausea, and constipation. Long-term use of opiates can produce addiction, and overuse can cause overdose and potentially death.

Examples of long-acting opiates:

1. Xtampza (Oxycodone)
2. Nucynta (Tamentadole)
3. Tramadol ER
4. Belbuca
5. Butrans

OPIOIDS AND MORPHINE DERIVATIVES EFFECTS

Short term effects:

1. Drowsiness
2. Slowed Breathing
3. Constipation
4. Unconsciousness
5. Nausea
6. Coma

Long-term effects:

Continued use or abuse of opioids can result in physical dependence and addiction. The body adapts to the presence of the drug and withdrawal symptoms occur of use is reduced or stopped. These include: restlessness, muscle and bone pain, insomnia, diarrhea, vomiting and cold flushes with goose bumps ('cold-turkey'). Tolerance can also occur, meaning that long0term users must increase their dose to achieve the same high.

Patient Name:________________________________ **(Printed)**

Signature: ____________________________________ **Date:**________________

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

NAME OF PATIENT: ______________________________ DATE: ____________________

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or to alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only to the physician, but also my physician's authorized associates, technical assistants, nurses, staff and other health care providers as might be necessary or advisable to treat your condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician Dr. Matthew Bennett, to treat my condition which has been explained to me as chronic pain. I hereby authorize to give my voluntary consent for my physician to administer or write prescription(s) for potentially dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result of taking these medication(s).

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the test or my refusal may lead to determination of treatment. The presence of unauthorized substances may result in my being discharged from your care.

For female patients only:

- To the best of my knowledge **I am NOT pregnant.**
- If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment.
- I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant
- **If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.**

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s), i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/fetus/baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension (low blood pressure), arrhythmias (irregular heartbeat), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

_______PATIENT'S INITIALS

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw form this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

PAIN MANAGEMENT AGREEMENT

I UNDERSTAND AND AGREE TO THE FOLLOWING:

That this pain management agreement relates to my use of any and all medication(s) (i.e. opioids, also called narcotics, painkillers, and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines may result in my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued.**
- I will disclose to my physician **all medication(s)** that I take at any time, prescribed by any physician.
- I will use the medication(s) **exactly as directed by my physician.**
- I agree **not to** share, sell, or otherwise permit others, including my family and friends, to have access to these medications.
- I will **not allow or assist in the misuse/diversion of my medication; nor will I give or sell them** to any one else.
- All medication(s) must be obtained at **ONE pharmacy, where possible.** Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to any pharmacist as needed.
- I understand that my medication(s) will be filled on a regular basis. I understand that my prescription(s) and medication(s) are exactly like money. **If either are lost or stolen, they may NOT BE REPLACED.**
- Refill(s) **will not be ordered before the scheduled refill date.** However, early refill(s) may be allowed when I am traveling and I **MAKE ARRANGEMENTS IN ADVANCE** of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency, post surgical, or the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function of quality of life from the medication(s), **my physician may try alternative medication(s) or may taper me off of all medication(s).**

______Patient Initials

- **I agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time with or without prior warning. If I test positive for illegal substance(s), such as speed, cocaine, etc., treatment for my chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to psychiatric or psychological evaluation by qualified physician such as addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.
- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life. This includes a multi-disciplinary approach possibly including many types of pain blocks, injections, spinal cord stimulator, surgical referral, etc. as indicated.
- I agree that **I shall inform any doctor** who may treat me for any other medical problems that I am enrolled in a pain management program, since the use of other medications may cause harm.
- I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medication(s) prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. Any unauthorized increase in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must keep all follow-up appointments as recommended by my physician or my treatment may be discontinued. If I miss my follow-up appointment, there will be no refill until the next available appointment.

I CERTIFY AND AGREE TO THE FOLLOWING:

1. I am NOT currently using illegal drugs or abusing prescription medications and I am NOT undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.
2. I have never been involved in the sale, illegal possession, the misuse/diversion or transport of controlled substances (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)
3. No guarantee or insurance has been made as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.
4. I have reviewed the side effects of the medications that may be used in the treatment of my chronic pain. I fully understand the explanation regarding the benefits and risks of these medications and I agree to the use of these medications in the treatment of my chronic pain.

I HAVE READ AND UNDERSTAND THIS AGREEMENT AND HAVE RECEIVED A COPY FOR MY RECORD.

____

Print Patient Name — Date of Birth

____

Patient Signature — Date

____

Physician Signature (or Appropriately Authorized Assistant) — Date

____

Name of Pharmacy — Phone Number

PLEASE READ AND SIGN TO ACKNOWLEDGE YOU UNDERSTAND

IT IS VERY IMPORTANT THAT YOU READ EACH POLICY LISTED BELOW. PLEASE INITIAL EACH ONE THAT YOU HAVE READ AND UNDERSTAND . IF YOU DO NOT UNDERSTAND OR HAVE A QUESTION REGARDING ANY ONE, PLEASE ASK BEFORE SIGNING.

_____Alabama Anesthesiology and Pain Consultants is a multi-disciplinary clinic using different approaches to most effectively treat and manage your chronic pain. Treatment may include, but not limited to: medication, physical therapy, chiropractic services, and/or pain management procedures. Our clinic does require compliance to the treatment plan our physician determines most effective for your condition; lack of compliance from the patient may result in dismissal from clinic.

____Please read in its entirety the 'Pain Management Agreement' included in your New Patient Paperwork Packet. This is a contract between AAAPC and any patient in our care being prescribed any narcotic medication. **ANY** outside narcotic medication prescribed by another physician is a direct violation of this agreement. Listed below are the **only** exceptions in which a narcotic may be prescribed by another physician- **HOWEVER**, medical records and/or verbal confirmation from the prescribing physician and/or authorized personnel is required.

____If you have an acute injury/condition (broken/fractured bone, dental emergency, etc.)

____If you have surgical procedure to treat a chronic or acute condition

It is best to check with our office first before filling any narcotic medication, as we can address any questions and concerns

____If your urine drug screen comes back negative for a narcotic we prescribe, another urine drug screen and/or a pill count may be ordered according to our discretion. A urine drug screen/pill count is a **MANDATORY** appointment.

____We have a **NO TOLERANCE** policy for any illicit drugs found in a urine drug screen. This includes, but certainly not limited to: cocaine, methamphetamine, etc. If an illicit drug is present in a urine drug screen, you will be referred to an inpatient detox center.

____If you are prescribed any type of benzodiazepine medication which include, but not limited to: xanax, klonopin, or any type of sleeping medication, please inform us the medication name, dosage and who the prescribing physician or psychiatrist is. If a narcotic is prescribed by our clinic, we will send a letter to the prescribing physician to discuss weaning due to the potential danger of mixing the medication.

****BY SIGNING BELOW**, I acknowledge that I have read and understand each of these policies as described in detail.

____

NAME DOB DATE