ADMISSION DATA MIDWEST PAIN CENTER

Date: _____ **Last Name:** _____ **First Name:** _____ **MI:** _____

M/F DOB: _____ **Home Phone:** _____ **Cell Phone:** _____

Address: _____
Street City State Zip

SSN: _____ **Employer:** _____ **Work Phone:** _____

Race: (African American) (American Indian/Alaska Native) (Asian) (Caucasian) **Ethnicity:** (Hispanic) (Non-Hispanic)
(please circle) *(please circle)*

Responsible Party Name and Address if Different from Above: _____

Relation to Responsible Party:_____ **Rspnsble Party DOB:** _____ **Rspnsble Party SSN:** _____

Responsible Party Employer: _____ **Employer Phone:**_____

Emergency Contact Name/Relationship: _____ **Phone:**_____

Referring Physician: _____

Primary Care Physician: _____

Surgeon: _____

Primary Insurance Co: _____ **Secondary Insurance Co:** _____

Policy Number: _____ **Policy Number:**_____

Group Number: _____ **Group Number:**_____

I, the above policy holder, with the aforementioned Insurance Company, herby authorize any benefits due me under this policy to be paid in accordance with this assignment. In consideration of surgical, medical and/or anesthesia services rendered), _____on _____, I hereby assign and transfer any benefits due me under
(Patient name) (date)
the above described contract as follows insofar, as they are necessary to cover the expenses.

A photo copy of this assignment shall be considered effective and valid as the original

---

FINANCIAL AGREEMENT

I hereby authorize direct payment to Midwest Pain Center of any insurance benefits otherwise payable to me for this admission at a rate not to exceed the regular charges. It is agreed that payment to Midwest Pain Center, pursuant to this authorization by an insurance company, shall discharge said insurance company of any and all obligations under a policy to the extent of such payment, I understand that I am financially responsible for charges not covered by this assignment. I understand that as a courtesy, Midwest Pain Center will file my primary insurance.

In consideration of the services to be rendered to me, I HEREBY INDIVIDUALLY OBLIGATE MYSELF TO PAY THE ACCOUNT OF MIDWEST PAIN CENTER IN ACCORDANCE WITH THE REGULAR RATE. Should the account be referred to an attorney or licensed collection agency for collection, I shall pay reasonable attorney's fees and collection expenses. All delinquent accounts (those not paid within sixty (60) days from date of services) shall bear interest at the legal rate.

I understand that Midwest Pain Center shall have the right at any time to refuse medical care or treatment for me.

I certify that I am the patient, or am duly authorized by the patient as patient's general agent, to execute this document and accept its terms.

Signed: _____ Dated: _____ Witness: _____

HIPAA AND PATIENT BILL OF RIGHTS GIVEN *Patient Initials:* _____ *Refused:* _____

PAIN QUESTIONNAIRE **MIDWEST PAIN CENTER**

Name_____ Date: _____
Date of Birth: _____ Patient's Age: _____

Past Medical History:

What medical problems do you have? Check the diseases

___Asthma	___Cancer	___High Blood Pressure	___COPD-Emphysema
___Diabetes	___Arthritis (DJD, Rheumatoid)	___Ulcers/GERD	___Stroke/CVA
___Bleeding Problems	___Heart (angina, heart attack)	___Kidney Problems	___Hepatitis C
___Sexually Transmitted Disease	___Abnormal Heart Beat	___High Cholesterol	___Anemia
___History of Infections	___Depression	___Osteoporosis	___Low Thyroid

List all medications, including over the counter: (continue on another sheet if necessary)

medication	**dosage**	**frequency**	**medication**	**dosage**	**frequency**

List any operations you have had and the dates:

A. _____ B. _____

C. _____ D. _____

List any severe accidents or trauma you have had and the dates:

A. _____ B. _____

List any psychiatric or psychological (depression/anxiety) care you have had or have now:

A. _____ B. _____

Drug Allergies: □ Yes □ No If so, please list: _____
Latex Allergy: □ Yes □ No

Social History:

Marital Status: ___married ___widowed ___divorced ___single
Do you smoke? ___No ___Yes ……How many packs a day? _____ How many years? _____
Do you drink? ___No ___Yes ……How may drinks per day? _____How many years? _____
Do you currently use illegal drugs? ___No ___Yes If yes what? _____
How many years? _____
Do you use alcohol or illegal drugs to treat your pain? ___No ___Yes

Family History:

List any chronic illness your mother or father has?

Mother _____ Father _____

_____ _____

PAIN QUESTIONNAIRE IMAGE **MIDWEST PAIN CENTER**

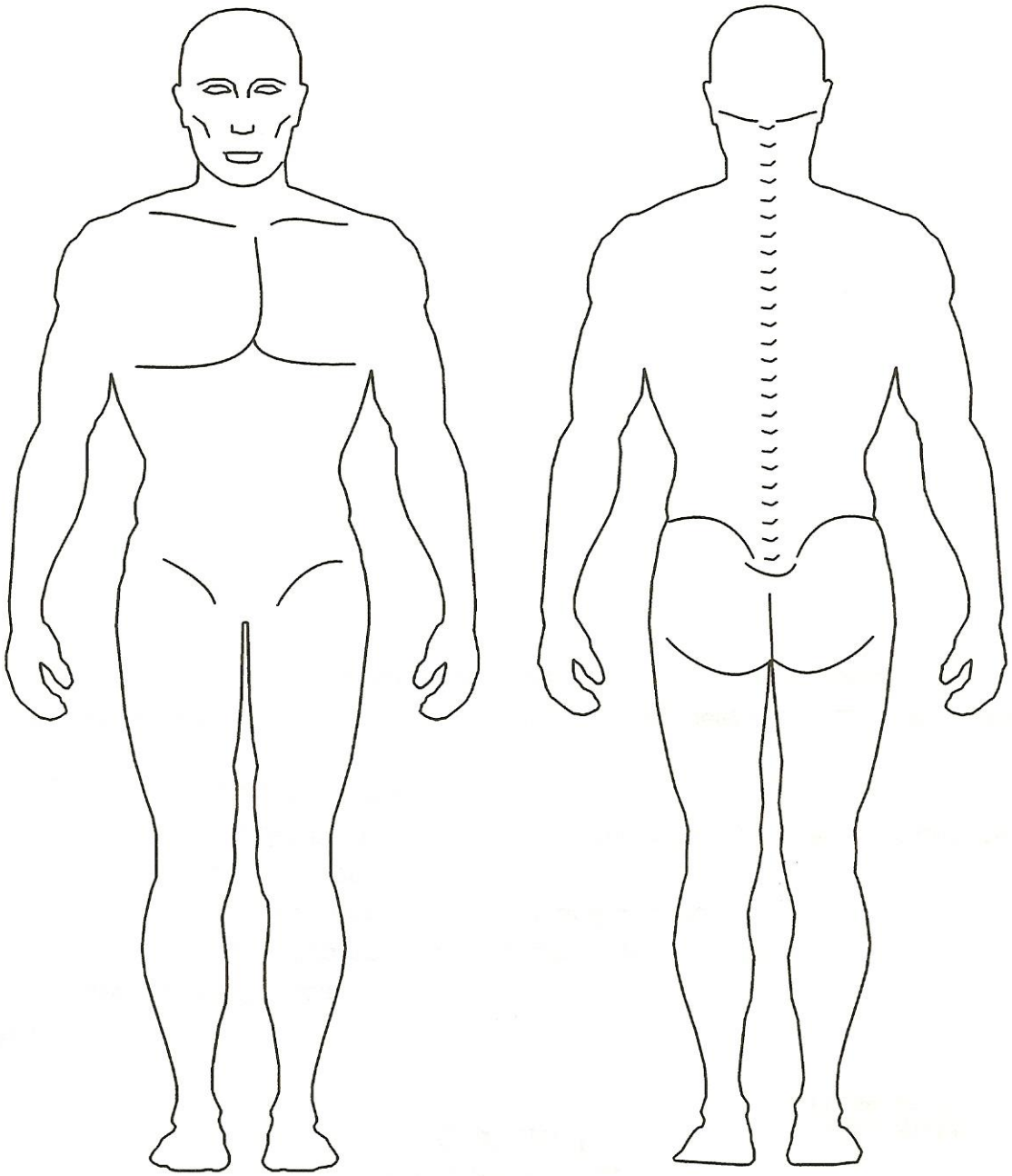
Name: _____ Date: _____
Date of Birth: _____ Patient's Age: _____

Rate your pain:

0 1 2 3 4 5 6 7 8 9 10

no pain **worst possible pain**

PLEASE MARK LOCATION OF YOUR PAIN WITH "X"



REVIEW OF SYSTEMS (ROS)

MIDWEST PAIN CENTER

Name: _____ ROS Date: _____

Date of Birth: _____ Patient's Age: _____

CONSTITUTIONAL SYMPTOMS:

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

EYES:

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

EARS/NOSE/MOUTH/THROAT:

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problem or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

CARDIOVASCULAR:

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath with walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes

RESPIRATORY:

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

GASTROINTESTINAL:

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain or heartburn	No	Yes
Peptic ulcer (stomach or duodenal)	No	Yes

GENITOURINARY:

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male-testicular pain	No	Yes
Female-pain with periods	No	Yes
Female-irregular periods	No	Yes
Female-vaginal discharge	No	Yes

Female-# of Pregnancies: _____ # of Miscarriages: _____

Female-date of last pap smear: _____

MUSCULOSKELETAL:

Joint Pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

INTEGUMENTARY (Skin, Breast):

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

NEUROLOGICAL:

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head Injury	No	Yes

PSYCHIATRIC:

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

ENDOCRINE:

Glandular of hormone problem	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

HEMATOLOGIC/LYMPHATIC:

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

ALLERGIC/IMMUNOLOGIC:

History of skin reaction or other adverse reaction to:		
Penicillin or other antibiotics	No	Yes
Morphine, Demerol, or other narcotics	No	Yes
Lidocaine or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, or other antiseptic	No	Yes

Allergies to any other drugs or steroids: _____

_____

Consent for Chronic Opioid Therapy MIDWEST PAIN CENTER

A consent form from the American Academy of Pain Medicine

Patient: _____ DOB: _____

Dr. Smith is prescribing opioid medicine, sometimes called narcotic analgesics, to me for a diagnosis of: _____. This decision was made because other treatments have not helped my pain.

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed included: physical therapy, psychological therapy and injection therapy.

I will tell my doctor about all other medicines and treatment that I am receiving.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for him or herself.

I am aware that certain other medicines such as nalbuphine (Nubain), pentazocine (Talwin), bupreorphine (Buprenex) and butorphanol (Stadol), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I'm taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is low. I am aware that the development of addiction as been reported in medical journals and is much more common in a person who has a family or a personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain, however, it has been seen and may occur to me. If it occurs, increasing doses may not respond well to opioids may cause my doctor to choose another form of treatment.

I am aware that if function decreases or does not improve, the medication with be discontinued.

(Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

(Females only) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking this medicine(s), the baby will be physically dependent upon opioids. I am aware the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

I have read this form or have had it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give consent for the treatment of my pain with opioid pain medicine(s).

Patient Signature:_____Witness: _____Date:_____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office rather than their home.

I wish to be contacted in the following manner (check all that apply):

☐ **Home Telephone**

- ☐ Ok to leave message with detailed information
- ☐ Leave message with call back number only

☐ **Written Communication**

- ☐ Ok to mail to home address
- ☐ Ok to mail my work address

☐ **Work Telephone**

- ☐ Ok to leave message with detailed information
- ☐ Leave message with call back number only

☐ I give permission for Dr. Smith to view my prescription history from external sources

I want to be web-enabled - Check your chart, appointments, vital signs, etc.

YES NO

PLEASE PRINT EMAIL ADDRESS: _____

NOTE: **Uses and disclosures may be permitted without prior consent in an emergency**.

Person(s) are authorized to receive your health information:

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

PATIENT SIGNATURE: _____ Date: _____

PRINT NAME: _____

NARCOTICS CONTRACT

Print Name:_____Date:_____Initials:_____

- **All opioid prescriptions MUST only come from Dr. Smith.**
- **All opioids must be obtained from the same Pharmacy (List your pharmacy contact information below).**
- **You may not share, sell, or permit access to these medications.**
- **Opioids should NOT be stopped suddenly, as withdrawal may occur.**
- **Medications may NOT be replaced if lost, get wet, destroyed, stolen, etc.**
- **Failure to follow the policies WILL result in the discontinuation of opioid therapy.**

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics, such as, hydrocodone, oxycontin, etc.), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

- When Dr. Smith is out of the office, your prescriptions cannot be refilled. It is **YOUR** responsibility to know when your refills are due. You must contact the office for refills prior to Dr. Smith being out of office.
- Patient initials: _____
- Inform the office RN's of any changes in medicine, new medical problems or side effects.
- Dr. Smith has permission to discuss all diagnostic and treatment details with your physicians or pharmacy, including drug screens.
- Random urine drug screens may be requested. Positive screens for illegal drugs, including marijuana, will lead to referral to a drug abuse center.
- Opioids should be closely safe guarded. They can be lethal and should be kept away from children and pets.
- Early refills are **NOT** given.
- If legal authorities have *q*uestions concerning your use of opioids - for example, if you are drug seeking, **ALL** confidentiality is waived and authorities may be given full access to your records.
- Renewals are dependent on keeping appointments. **Please call for refills during office hours ONLY**.

- It is understood that **ALL** treatment with opioids is **TRIAL** and continued use is **BASED ON EFFECTIVENESS/IMPROVED FUNCTION**.
- The risks and benefits of opioid therapy is explained elsewhere and you should have received this information.
- All treatment options **MUST** be investigated prior to or during opioid treatment, including injections, physical therapy, and chiropractic care.
- Long acting opioids are the **RULE**.

You agree that you have full right and power to sign and be bound by this agreement and that you have read, understand and accept all of these terms.

_____ _____

Patient Signature ***Physician Signature***

_____ _____

Patient Name (Printed) ***Date***

_____ _____

PHARMACY NAME **PHARMACY PHONE #**

Notice of Privacy Practices
MIDWEST PAIN CENTER

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

If you have any questions about this notice, please contact Lisa Smith @ 636-728-1977

OUR OBLIGATIONS: We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

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

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and

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 Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information 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 Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency 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 Health 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 also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if 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) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

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

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the facility. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you

have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to **Lisa Smith.**

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to **Becky Hackett**.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to **Lisa Smith**. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the facility. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact us at **636-728-1977**.

CHANGES TO THIS NOTICE:

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

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Senior Services P.O. Box 570, Jefferson City,MO 65102-0570. Phone 1-573-751-6303. Hearing and Speech Impaired. 1-800-735-2966.To file a complaint with our office, contact **Lisa Smith @ 636-519-8889.** All complaints must be made in writing. **You will not be penalized for filing a complaint**.

*Web site for the Medicare Beneficiary Ombudsman: www.medicare.gov/ombudsman/resources.asp or 1-800-633-4227.

Revised 01/9/2017

MIDWEST PAIN CENTER

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

The staff of this health care facility recognizes you have rights while a patient receiving medical care. In return, there are responsibilities for certain behavior on your part as the patient. These rights and responsibilities include:

A patient has the *right* to

- be treated with courtesy and respect, with appreciation of his individual dignity and with protection of his need for privacy.
- a prompt and reasonable response to questions and requests.
- know who is providing medical services and who is responsible for his care.
- know what patient support services are available, including whether an interpreter is available if he does not speak English.
- know what rules and regulations apply to his conduct.
- be given by his health care provider information concerning diagnosis, a planned course of treatment, alternatives, risks and prognosis.
- refuse treatment, except as otherwise provided by law.
- be given, upon request, full information and necessary counseling on the availability of known financial resources for his care.
- know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- receive a copy of a reasonable clear and understandable itemized bill and, upon request, to have charges explained.
- impartial access to medical treatment or accommodations regardless of race, national origin, religion, physical disability or source of payment.
- treatment for an emergency medical condition that will deteriorate from failure to provide treatment.
- know if medical treatment if for purpose of experimental research and to give his consent or refusal to participate is such experimental research.
- express concerns regarding any violation of patient rights.
- have the right to change primary or specialty physicians or dentists if other qualified physicians or dentists are available.

A patient is *responsible* for

- providing to his health care provider, to the best of his knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his health.
- reporting unexpected changes in his condition to his health care provider.
- reporting to his health care provider whether he comprehends a contemplated course of action and what is expected of him.
- following the treatment plan recommended by his health care provider.
- keeping appointments.
- his actions if he refuses treatment or does not follow the health care provider's instructions.
- assuring that the financial obligations of his health care are fulfilled as promptly as possible.
- following health care facility rules and regulations affecting patient care and conduct.

COMPLAINTS

If you have a question or concern about your rights and responsibilities, please let us know. We want to assure that we provide you with excellent service, including answering your questions and responding to your concerns.

FOR YOUR RECORDS