PATIENT WELCOME PACKET

Pain Care Specialists of Oregon's Mission:

Our mission is to provide the best possible pain management in a caring environment. We offer the most advanced interventional pain management treatments to ideally help those in chronic pain avoid narcotics. We are committed to excellence through continuing education, researched techniques, and state-of-the-art equipment. We will value each individual and family. Our goal is to be recognized as the premier interventional pain management clinic by consistently providing excellent medical service based upon timely, knowledgeable, compassionate care from the moment you come through the door until you leave. We strive to have patients choose Pain Care Specialists of Oregon for optimal medical attention for themselves, their family and their community.

Pain Care Specialists
www.paincareoregon.com

Pain Care Specialists
www. paincareoregon.com
2480 Liberty Street NE, Suite 180, Salem, OR 97301
Phone: (503) 371-1010 Fax: (503) 371-0805

Patient Demographics

Name: .....

Address: .....

Home Phone: .....Cell Phone: .....

SSN#: ..... DOB (mm/dd/yyyy): ...../...../.....

Primary Care Physician: .....

Emergency Contact

Name: .....

Relationship: ..... Phone: .....

Grant permission to access medical information ☐ Yes ☐ No

Race and Ethnicity Survey

Please place a check indicating one choice under race and one choice under ethnicity. You are under no obligation to answer any of the questions below.

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Decline
- ☐ Unknown
- ☐ Other.....

Ethnicity

- ☐ Hispanic or Latino Ethnicity
- ☐ Non Hispanic or Latino Ethnicity
- ☐ Decline
- ☐ Unknown

Language

- ☐ English
- ☐ Spanish
- ☐ Russian
- ☐ Other.....
- ☐ Indian (includes Hindi & Tamil)

Advance Directive

- ☐ Advance Directive
- ☐ Do Not Resuscitate Order (DNR)
- ☐ None on file

Grant Permission to leave message

- ☐ Leave message on home phone
  - ☐ Voice ☐ Text
- ☐ Leave message on cell phone*
  - ☐ Voice ☐ Text
- ☐ Email message to my email address: .....

* Charges may be added by your carrier per your plan policy.

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Name: ..... DOB: ...../...../.....

New Patient Intake Form, Page 1 of 3

The pain is located mainly at the: (check one)

☐ Neck ☐ Mid Back ☐ Low Back ☐ Shoulder ☐ Hip ☐ Knee ☐ Other.....

The pain feels like: (check all that apply)

☐ Sharp/stabbing ☐ Dull/achy ☐ Like muscle spasms ☐ Burning ☐ Like numbness/tingling ☐ Other

Does the pain radiate or travel? (check one) ☐ Yes ☐ No (if yes, where?).....

Do you have areas of numbness?: (check one) ☐ Yes ☐ No (if yes, where?).....

Do you have areas of weakness: (check one) ☐ Yes ☐ No (if yes, where?).....

The pain started: (check one)

☐ Less than 6 months ago ☐ More than 6 months ago ☐ More than 1 year ago ☐ More than 5 years ago ☐ More than 10 years ago

Is this pain related to a motor vehicle accident? (check one) ☐ Yes ☐ No DOI: .....

Is this pain related to a work injury? (check one) ☐ Yes ☐ No DOI: .....

Is this pain related to a surgery? (check one) ☐ Yes ☐ No NOTE: .....

The pain increases with: (check all that apply)

☐ Sitting ☐ Walking ☐ Standing ☐ Bending forward ☐ Bending backward ☐ Looking up ☐ Looking down

The pain decreases with: (check all that apply) ☐ Rest ☐ Medication ☐ Exercise/physical therapy ☐ Procedures

Medications: (check one) ☐ Do help relieve my pain ☐ Do not help relieve my pain ☐ Cause side effects

Medications tried: (Check all that apply)

☐ Ibuprofen ☐ Tylenol ☐ Nortriptyline ☐ Amitriptyline ☐ Gabapentin ☐ Lyrica ☐ Flexeril
☐ Robaxin ☐ Zanaflex ☐ Skelaxin ☐ Hydrocodone ☐ Oxycodone ☐ Oxycontin ☐ Morphine
☐ MS Contin ☐ Methadone ☐ Dilaudid ☐ Suboxone ☐ Nucynta ☐ Fentanyl ☐ Opana

Other: .....

Are you currently taking an anticoagulant? (check one) ☐ Yes ☐ No

Indicates options therapies tried: (Check all that apply) ☐ None ☐ Physical Therapy ☐ Massage ☐ Acupuncture ☐ Chiropractic treatments ☐ TENS unit ☐ Pain psychology/therapy

Procedures previously tried related to your current or past pain: (Check all that apply)

☐ None ☐ Epidural steroid injection ☐ Facet joint injection ☐ Radiofrequency ablation
☐ Trigger point injections ☐ Joint injection ☐ Spinal Cord Stimulator ☐ Botox injection

Office Use Only:

Heart Rate:.....Blood Pressure: ...../.....Temp: .....F. Pulse..... Ox. .....% Resp:.....

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Name: ..... DOB: ...../...../.....

New Patient Intake Form, Page 2 of 3

Current Medications:

Name:..... Dose:..... Frequency: .....
Name:..... Dose:..... Frequency: .....
Name:..... Dose:..... Frequency: .....
Name:..... Dose:..... Frequency: .....
Name:..... Dose:..... Frequency: .....
Name:..... Dose:..... Frequency: .....
Name:..... Dose:..... Frequency: .....

Current Medical Problems:

.....
.....
.....
.....

Allergies: (check all that apply)

☐ None ☐ Tape ☐ Omnipaque ☐ Latex ☐ Iodine ☐ Other: .....

Medication Allergies (list):

.....
.....

Surgical History (Check all that apply and circle for Left/Right)

☐ Cardiac/Heart ☐ Cervical/Neck ☐ Lumbar/Back ☐ Hip Left/Right ☐ Knee Left/Right ☐ Shoulder Left/Right

Past Hospitalizations:

Date:..... Reason:..... Date:..... Reason:.....
Date:..... Reason:..... Date:..... Reason:.....
Date:..... Reason:..... Date:..... Reason:.....

Family History: (Please check where applicable)

	Father	Mother	Grandparent	Sibling
Heart Disease	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Stroke	☐	☐	☐	☐

Social History: (Please check Yes or No for each question)

Smoking: ☐ Yes ☐ No (.....packs per day/week)
Alcohol: ☐ Yes ☐ No (.....drinks per day/week)
Illegal Drugs ☐ Yes ☐ No Date last used:.....
Addiction/Dependency ☐ Yes ☐ No
Marijuana ☐ Yes ☐ No

Married: ☐ Yes ☐ No ☐ Divorced
Children: ☐ Yes ☐ No How many?.....
On Disability: ☐ Yes ☐ No
Currently Working: ☐ Yes ☐ No

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Name: ..... DOB: ...../...../.....

Please check Yes or No for each question

Bowel incontinence:	☐ Yes / No ☐	Muscle pain and spasm:	☐ Yes / No ☐
Bladder incontinence:	☐ Yes / No ☐	Weakness:	☐ Yes / No ☐
Nausea:	☐ Yes / No ☐	Headache:	☐ Yes / No ☐
Vomiting:	☐ Yes / No ☐	Tingling/numbness:	☐ Yes / No ☐
Fevers:	☐ Yes / No ☐	Constipation:	☐ Yes / No ☐
Chills:	☐ Yes / No ☐	Change in vision:	☐ Yes / No ☐
Sinus congestion:	☐ Yes / No ☐	Shortness of breath:	☐ Yes / No ☐
Chest pain:	☐ Yes / No ☐	Depression:	☐ Yes / No ☐
Weight loss:	☐ Yes / No ☐	Suicidal thoughts:	☐ Yes / No ☐
Rash:	☐ Yes / No ☐	Suicide attempts:	☐ Yes / No ☐
Diabetes:	☐ Yes / No ☐	Attention Deficit Disorder:	☐ Yes / No ☐
Hearing loss:	☐ Yes / No ☐	Obsessive Compulsive Disorder:	☐ Yes / No ☐
Chance of being pregnant:	☐ Yes / No ☐	Bipolar:	☐ Yes / No ☐
Trouble swallowing:	☐ Yes / No ☐	Schizophrenia:	☐ Yes / No ☐
Abnormal bruising or bleeding:	☐ Yes / No ☐	Mental health changes:	☐ Yes / No ☐
Hepatitis C positive:	☐ Yes / No ☐	Undergoing counseling:	☐ Yes / No ☐
HIV positive:	☐ Yes / No ☐	High stress level:	☐ Yes / No ☐
Change in sexual function:	☐ Yes / No ☐	Psychiatric hospitalization:	☐ Yes / No ☐
Homicidal ideation:	☐ Yes / No ☐		

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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 right or wrong answers.

Name: …… **Date of Birth:** ……	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
	0	1	2	3	4
1. How often do you have mood swings?	☐	☐	☐	☐	☐
2. How often have you felt a need for higher doses of 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 in the 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 have 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?	☐	☐	☐	☐	☐

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

PainEDU.org
IMPROVING PAIN TREATMENT THROUGH EDUCATION

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Name: …… **Date of Birth:** ……	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	☐	☐	☐	☐	☐
14. How often have others 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 pain 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 been arrested?	☐	☐	☐	☐	☐
19. How often have you attended an AA or NA meeting?	☐	☐	☐	☐	☐
20. How often have you been in an argument that was so out of control that 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?	☐	☐	☐	☐	☐
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 above answers.

Thank you.

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NOTICE OF PRIVACY PRACTICES

This notice describes how you can get access to your medical information and how medical information about you may be used and disclosed.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you, treatment, and services we provide to you. We are required by law to maintain the confidentiality of your PHI. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information:

HOW WE MAY USE AND DISCLOSE YOUR PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice maintained or created in the past and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current notice in our office in a visible location at all times, and you may request a copy of our most current notice at any time.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Practice Manager of Pain Care Specialists of Oregon, LLC, (503) 371-1010.

WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:

Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may ask you to use the results to help us reach a diagnosis. We may use your PHI in order to write a prescription for you, or we may disclose your PHI to a Pharmacy when we order a prescription for you. Many of the people who work for our practice including, but not limited to, our doctors and nurses-may use or disclose your PHI to others who may assist in your case, such as your friends or family members involved in your care.

Payment. Our practices may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits. We may provide your insurer with details regarding your treatment to determine if your insurer will cover or pay for your treatment. We may use your PHI to obtain payment from third parties that may be responsible for such costs. We may use your PHI to bill you directly for services and items.

Heath Care Operations. Our practice may use and disclose your PHI to operate our business. As an example of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us to conduct cost-management and business planning activities, or to train new health care workers.

Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member who is involved in your care or who assists in taking care of you. For example, a guardian may ask that a neighbor take an adult or child to the physician's office for treatment. This neighbor may have access to this patient's medical information. We may also release information to friends or family members involved in your payment for health services we provide.

Disclosures Required by Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES WITHOUT APPROVAL

Public Health Risks. Our practices may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records such as births and deaths Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device has been recalled
- Notifying appropriate government agencies and authorities regarding domestic abuse, potential abuse or neglect of an adult patient; however, we will only disclose this information if the patient agrees or we are required by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and health care system in general. We may use your information to report diseases to the health department.

Lawsuits and Similar Proceedings. Our practice may disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute after we inform you of the request to obtain an order protecting the information the party has requested.

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

- Regarding a crime victim in certain situations
- Concerning a death possibly due to criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or a missing person
- In an emergency to report a crime (including the location or victim(s) of the crime or the description, identity or location of the perpetrator)

Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

YOUR RIGHTS REGARDING YOUR PHI

Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For example, you may ask that we contact you at home, rather than work, or to send communications in a sealed envelope instead of a postcard. You may be asked to pay for additional costs incurred to comply with your request. In order to request a type of confidential communication, you must make a written request to our Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI only to certain individuals such as family members and friends involved in your care or the payment of your care. You may request to not have trainees or others involved in your care. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to our Privacy Officer. Your request must describe in a clear concise fashion:

- The information you wish restricted
- Whether you are requesting to limit our practice's use, disclosure, or both; and
- To whom you want the limits to apply

Inspection Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you. You must submit your request in writing to Privacy Officer 2480 Liberty St NE, Ste 180, Salem, OR 97301. Our practice may charge a fee for the costs of copying associated with your request.

Amendment. You may ask to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Privacy Officer. You must provide it with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit in writing your request and the reason supporting your request. Also, we may deny your request if you ask us to amend information that is in our opinion:

(a) accurate and complete; (b) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice.

Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain disclosures required to list your PHI as part of the routine patient care, payment, or health operations in our practice for paper records. Examples of routine patient care, payment or health operations excluded from an accounting from paper charts include the doctor sharing information with the nurse, billing department using your information to file your insurance claim, and discussion of your PHI for purposes of improving our health care delivery

system. In order to obtain an accounting you must submit your request in writing to the Privacy Officer 2480 Liberty St NE, Ste 180, Salem, OR 97301. All requests for "accounting of disclosures" must state a time period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to Paper Copy of This Notice. You are entitled to receive a paper copy of our Notice of Privacy Practices. You will be offered a copy on your first visit to the practice. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact our Privacy Officer at (503) 371-1010.

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with our Secretary of the Department of Health and Human Service Office of Civil Rights, 500 Summer St NE, Salem, Oregon 97301, (503) 945-5944. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to Provide and Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not covered by this notice or permitted by law, such as for research or marketing. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your PHI for the reasons described in the authorization, we are required to retain records for your care.

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PAIN CARE SPECIALISTS OF OREGON, LLC, HIPAA CONSENT

By signing this Consent Form, you give Pain Care Specialists of Oregon, LLC (PCSO), permission to use and disclose protected health information about you for treatment, payment, and healthcare operation except for any restrictions specified in the Form to Request Restrictions. Protected health information is individually identifiable information created or received by the practice, including demographic data, information relating to your physical or mental health, to provision of healthcare services to you, and to the collection of payment for providing healthcare services to you.

If the information to be disclosed contains any of the type of records or information for drug/alcohol diagnosis, treatment, or referral information, mental health information, genetic testing information, and HIV/AIDS information, additional laws relating to the use and disclosure of the information may apply. As the patient, you have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

The PCSO Notice of Privacy Practices (NOPP) provides information about how PCSO may use and disclose protected health information about you. A copy of this notice of Privacy Practices is available to you for review prior to signing the Consent Form. As referenced in the Notice, the terms of the Notice of Privacy Practice may be changed periodically. Copies of the most current notice will be available at your request upon check-in for your appointment or by accessing the practice's website at www.paincareoregon.com. Should you have any questions or concerns about the handling of your protected health information, you may contact the PCSO Manager at (503) 371-1010.

You have the right to request restriction on the use or disclosure of you protected health information for treatment, payment, or healthcare operations. If your request for restriction is accepted, then the practice is bound to honor that agreement.

With this consent, PCSO may call your home or alternative location and leave a message or voicemail with an individual in reference to any items that assist the practice such as appointment reminders, insurance items, and any call pertaining to your clinical care, including test results. With this consent, PCSO may mail to your home or alternative location any items that assist the practice such as appointment reminder cards and patient statements.

To the extent available, PCSO may attempt to electronically obtain your prescription medication history through your insurance provider and prescription benefits service. By signing this Consent Form you consent to any electronic download of said information which may be useful to your treatment.

If you elect not to sign this Consent Form, PCSO has the right to refuse you treatment unless a licensed healthcare professional has determined that you require emergency treatment or the physician is required by law to treat you. The practice is required to document any circumstances in which treatment is provided without your consent; a copy of this documentation would be available to you.

You have the right to revoke this consent in writing unless disclosure has been made based upon your prior consent. To request your revocation, you may use the Authorization for Release of Information Form or you may submit a letter to the practice.

I acknowledge that PCSO has offered a copy of the NOPP which includes the updated HIPAA OMNIBUS rule.

.....

Signature of Patient or Legal Representative Date

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ASSIGNMENT OF BENEFITS FOR LABORATORY TESTING

I, the referenced patient, understand that services rendered to me by Pain Care Specialists of Oregon, LLC, physicians and/or other healthcare providers are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Pain Care Specialists of Oregon, LLC, and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay in a current manner, any balance of said professional service charges over and above this insurance payment. I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim. In providing this consent, I am fully aware that the physicians of Pain Care Specialists of Oregon, LLC, the staff, and employees cannot be responsible for the confidentiality of the information disclosed after medical records have been released. Therefore, the physicians of Pain Care Specialists of Oregon, LLC, the staff, and employees are released from liability arising from such disclosure.

I also understand that should my insurance company send payment to me, I will forward the payment to Pain Care Specialists of Oregon, LLC, within forty-eight (48) hours. I agree that if I fail to send the payment to Pain Care Specialists of Oregon, LLC, and they are forced to proceed with the collections process, I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Pain Care Specialists of Oregon, LLC, to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize Pain Care Specialists of Oregon, LLC, to initiate a complaint or file appeals to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

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DISCLOSURE OF PHYSICIAN OWNERSHIP

The physicians at Pain Care Specialists of Oregon, LLC, may have ownership in one or more of the following entities: Pain Care Specialists of Oregon, Oregon Specialists Surgery Center, and Oregon Pain Management. A list of physician ownership is available upon request.

You have a right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than the one to which you were referred.

You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

PATIENT FINANCIAL CONSENT

Copayment is due on the day of service, unless payment arrangements have been previously arranged. Pain Care Specialists of Oregon, LLC, will submit insurance claims for you. However, if the service is not covered under your policy, you are responsible for the balance due. This may include additional patient responsibility charges for procedures performed same day as office visit. It is the policy of Pain Care Specialists of Oregon, LLC, to work diligently to assist patients with financial arrangements. Extended payment plans can be arranged through our billing office. These plans are based upon financial circumstances of each patient. We invite you to discuss any financial difficulties by calling our office at (503) 371-1010. If insurance requires that a referral is necessary it is the responsibility of the patient to obtain one from their primary care physician before an appointment with a Pain Care Specialists of Oregon, LLC, physician. Pain Care Specialists of Oregon, LLC, reserves the right to refuse service to any patient who does not have a valid referral in our office at the time of their appointment. Many of the services that our office provides require pre-authorization, and we ask that you be patient with our office in obtaining this authorization. Many insurance companies require documentation prior to authorizing services, and we will do our best to comply in a timely fashion with their requests.

Consent to Release Information:

I (the patient/guarantor) hereby give my consent to Pain Care Specialists of Oregon, LLC, to release any information regarding my care and treatment as may be required in connection with payment. I authorize the release of any medical documentation to insurance companies and medical providers as necessary.

Assignment of Benefits:

I (the patient/guarantor) hereby authorize payment to be rendered directly to Pain Care Specialists of Oregon, LLC, for the benefits otherwise payable to me by any third party. The above authorizations are in effect permanently or until canceled by myself in writing.

Medicare Signature on File:

I (patient/guarantor) request that payment under the medical insurance program Medicare to be made to Pain Care Specialists of Oregon, LLC, on any bills for services furnished to me by the physicians of Pain Care Specialists of Oregon, LLC, permanently or until this authorization in canceled by me (the patient/guarantor) in writing. I also give Pain Care Specialists of Oregon, LLC, authorization to file claims to Medicare on my behalf.

Pain Care Specialists of Oregon, LLC, reserves the right to charge a $50 fee if the patient fails to give at least 24-hour cancellation notice or "no show" to their appointment. This fee will be paid by the patient/guarantor regardless of insurance. We reserve the right to charge a $200 fee if the patient fails to check in for a procedure or cancel the procedure without providing at least 24 hours' advance notice. This fee is not billable to insurance.

I have read this policy and understand that delinquent accounts may be assigned to a credit reporting and collection service.

CANCELLATION AND NO SHOW POLICY FOR CLINIC APPOINTMENTS

Your appointment is reserved especially for you, and when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. We also understand that delays can happen. However, in fairness to other patients, if you do not arrive 30 minutes prior to your scheduled new patient visit we may need to reschedule your appointment to another day. If you arrive more than 5 minutes past your actual appointment time you will be rescheduled. No controlled substances will be prescribed without an appointment. We kindly request that you notify us at least 24 hours in advance should you need to cancel or reschedule your appointment. Please contact our office hours are 8:00AM-4:00PM Monday through Thursday, and 8:00AM-3:00PM Friday at (503) 371-1010. Each time you cancel or "no show" your appointment with less than 24 hours' notice, you will be subjected to a $50.00 fee, and this fee is not billable to insurance. You may be dismissed from the clinic if you cancel or "no show" your appointment less than 24 hours of your scheduled time more than three times per year.

CANCELLATION AND NO SHOW POLICY FOR PROCEDURES

Please carefully consider your procedure date before scheduling. When rescheduling has to occur, the scheduling process adds to the administrative expenses for the clinic. **If you fail to check in for your procedure, or if you cancel the procedure with less than 24 hours' notice, you will be subjected to a $200.00 fee, and this fee is not billable to insurance. You may be dismissed from the clinic if you cancel or "no show" your appointment less than 24 hours of your scheduled time more than twice per year.**

PAIN CARE SPECIALISTS OF OREGON URINE DRUG TESTING POLICY

Opioid pain medications (also known as opiate or narcotic pain medications) are a potentially valuable source of relief for those suffering from chronic pain. They are also dangerous substances that carry the risk of bowel obstruction, liver failure, kidney failure, cardiac arrhythmia, respiratory depression, and death. These medications are some of the most potentially addictive substances. Use of these medications carries risk of dependence, tolerance, withdrawals, increased pain with chronic use, depression and anxiety. The use of these substances should not be taken lightly. Pain Care Specialists of Oregon (PCSO) providers will use a combination of factors to determine if a patient is a good candidate for opioid therapy. These factors include the patient's medical, surgical, and family history. The patient will be given assessments such as the Opioid Risk Tool and the Oswestry Disability Index to make sure that the opioid therapy is appropriately treating the patient's pain. Mixing opioid pain medications with other controlled substances can be extremely dangerous. Substances such as benzodiazepines, medical marijuana, alcohol and Soma/carisoprodol can increase the risk of complications or death in an opioid patient by up to 100%. PCSO may limit or discontinue opioid therapy in patient's taking benzodiazepines or Soma/carisoprodol. Patients who are treated with opioid pain medications at PCSO will sign an opioid agreement. PCSO will provide no more than a 28-day supply of any opioid medication, although exceptions may be made at the discretion of the prescribing provider given very specific circumstances after discussion with colleagues. All patients are required to be physically present at the clinic to obtain a script. All new patients taking an opioid or benzodiazepine will be required to provide a urine drug test sample. This sample will undergo confirmation testing. If patients are unable to provide a urine

sample, we may collect a saliva or blood sample instead. Blood or saliva samples may be sent to a specialty lab where additional charges may occur. Patient drug testing will be based on the PCSO Urine Drug Testing Algorithm and proprietary Patient Randomizing Software. Urine testing may occur at clinic visit and/or walk-in testing. Patients who are informed that a urine sample is required will have 3 days to provide the urine sample. Some patients at high doses and high risk may be required to have two (2) urine drug tests within a 30-day period. Patients may be required to provide random urine drug test samples, cognitive testing, pharmacy reports and pill counts at any time. These guidelines promote safe and appropriate patient medication use. You will be responsible for all bills associated with these required tests per your insurance benefits.

PATIENT INFORMED CONSENT FORM FOR POST EXPOSURE LABORATORY TESTS

PCSO is requesting your permission to have your blood drawn and tested for Hepatitis B Surface Antigen, Hepatitis C Surface Antigen, and Human Immunodeficiency Virus in case an employee or physician is accidently exposed to your blood or contaminated body fluids. In order to establish if our employee or physician has been exposed to one of these infectious diseases, the Occupational Safety and Health Administration (OSHA) requires permission from you to perform these tests.

You will not be financially obligated for these tests.

The records of the test results will be kept confidential and are not disclosed without your written consent to any person within or outside the facility except as required by law. A copy will be provided to you at your request.

I have read the above statement and understand the importance of this lab test process for the protection of Pain Care Specialists of Oregon employees and physicians.

I do agree to have the above tests done, and I understand the test results will be acquired by Pain Care Specialists of Oregon, LLC.

By signing this form, you agree that you have read and understand the above policies.

……

Patient or Legal Representative Name Date

……

Signature of Legal Representative Date

……

Patient's Date of Birth

Pain Care Specialists
www. paincareoregon.com

2480 Liberty Street NE, Suite 180, Salem, OR 97301
Office: (503) 371-1010 Fax: (503) 371-0805

This authorization must be completed, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize _____ to release a copy of the medical information for _____ (Name of Patient/DOB)
to Pain Care Specialists of Oregon (Name of Recipient)
Mailing Address 2480 Liberty St. NE Suite180, Salem OR. 97301 or Fax Number 503-371-0805

The information will be used on my behalf for the following purpose(s):

_____

By initialing the spaces below, I specifically authorize the release of the following records, if such records exist:

- ☐ All hospital records (including nursing records and progress notes)
- ☐ Transcribed hospital reports
- ☐ Medical records needed for continuity of care
- ☐ Most recent five year history
- ☐ Laboratory reports
- ☐ Pathology reports
- ☐ Diagnostic imaging reports
- ☐ Clinician office chart notes
- ☐ Dental records
- ☐ Physical Therapy records
- ☐ Emergency and urgency care records
- ☐ Billing statements
- ☐ Other

Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

- ☐ *HIV/AIDS-related records
- ☐ *Genetic testing information

*Must be specifically selected to be included in other documents.

☐ **Drug/Alcohol diagnosis, treatment or referral information_____

**Federal Regulation 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.

- ☐ This authorization is limited to the following treatment: _____
- ☐ This authorization is limited to the time period: _____
- ☐ This authorization is limited to a worker's compensation claim for injuries of: _____

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization, unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____
(Date) (Signature of patient)

_____ _____
(Date) (Signature of person authorized by law)

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MEDICAL RECORDS RELEASE FORM

This authorization must be completed, dated, and signed by the patient or by a person authorized by law to give authorization.

I…… (Name of Patient) …….. (DOB), authorize …… (Provider/Facility) that has provided me medical treatment to release copies of my medical records (except for HIV/AIDS related records, genetic testing information, or Drug and Alcohol diagnosis and/or treatment information) to:

PAIN CARE SPECIALISTS OF OREGON
2480 LIBERTY ST NE, STE 180
SALEM, OR 97301

For records within the date range of …… to ……

And/Or:

Name of Recipient: ……
Mailing Address: ……
Fax Number: ……
For records within the date range of …… to ……

The information will be used on my behalf for continuity of care. Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record. This authorization may be revoked at any time. This release will be valid for 1 year from the date signed.

……
Signature of Patient Date

……
Signature of person authorized by law Date

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PERMISSION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION TO A FAMILY MEMBER, FRIEND OR LEGAL REPRESENTATIVE

IMPORTANT NOTE: The law prohibits release of confidential medical information to any entity without the written, voluntary consent of the undersigned patient.

I…… (Name of Patient) …… (DOB), give permission for Pain Care Specialists of Oregon, LLC, or their designated representative to communicate information about my medical condition and treatment to:

Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship

Printed Name of Patient	Signature	Date
Printed Name of Representative	Signature	Date