PATIENT LAST NAME	FIRST NAME	MI	SEX
ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH:	HOME PHONE:	CELL PHONE:	REFERRAL SOURCE:

MARITAL STATUS	EMPLOYMENT STATUS	Preferred Language	Ethnicity	Race:
☐ Single ☐ Married ☐ Other	☐ Employed ☐ Not Employed ☐ Student	☐ English ☐ Hindi ☐ Spanish ☐ Decline to report ☐ French	☐ Latino/Hispanic Identity ☐ Not Latino or Hispanic ☐ Decline to report	☐ White ☐ Asian ☐ Latino/Hispanic ☐ Black ☐ Native Hawaiian ☐ American Indian ☐ Alaska Native

EMAIL ADDRESS:			
EMERGENCY CONTACT:	RELATIONSHIP TO PATIENT:	PHONE NUMBER:	
ADDRESS:	CITY:	STATE:	ZIP:

PRIMARY INSURANCE

COMPANY NAME:		POLICY NUMBER:	GROUP NUMBER:
ADDRESS:			
CITY:	STATE ZIP	RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	
RESPONSIBLE PARTY IF OTHER THAN PATIENT		HOME PHONE:	WORK PHONE:
ADDRESS:	CITY: STATE ZIP		
EMPLOYER:	DATE OF BIRTH:	SEX ☐ MALE ☐ FEMALE	

SECONDARY INSURANCE

COMPANY NAME:		POLICY NUMBER:	GROUP NUMBER:
ADDRESS:			
CITY:	STATE ZIP	RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	
RESPONSIBLE PARTY IF OTHER THAN PATIENT		HOME PHONE:	SEX ☐ MALE ☐ FEMALE

EMPLOYMENT

COMPANY NAME:		LENGTH OF EMPLOYMENT:
ADDRESS:		
CITY:	STATE ZIP	IS THIS WORKERS COMP RELATED: ☐ YES ☐ NO
SUPERVISOR NAME:		CONTACT NUMBER:

ASSIGNMENT OF BENEFITS / RELEASE INFORMATION

I hereby assign all insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance, major medical benefits and any other health plans to the assigned physician. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including HIV, substance abuse or psychiatric information which may be found in the record and is necessary to secure payment. I hereby consent to contact via cell phone for any reason including appointment information, billing questions or collection concerns.

Patient or Responsible Party:_____ Date: _____

How did you hear about us? ☐ Yellow Pages ☐ Insurance Company ☐ Referring Physician ☐ Friend

PRC ALLIANCE PAIN RELIEF CENTERS

PATIENT INFORMATION SHEET (1 OR 3)

Patient Name: _____ Date of Birth:_____

Primary Care/Family Physician: _____

Referring Physician if Different: _____

Are you employed: ☐ Yes ☐ No Are you currently on ☐ Disability ☐ Workman's Compensation?

If yes to workman's compensation: Claim Number: _____ Date of Injury:_____

Adjusters Name: _____ Phone Number: _____

Involved in pending litigation: ☐ yes ☐ no If yes, Attorney name: _____

PAIN HISTORY:

Location of Pain: _____

Severity of pain: ___ Mild ___ Moderate ____Severe

When did you first experience pain (Year) _____

Under what circumstances did pain begin? ____ Home ____ Work ____Automobile _____ Post-Surgical

If **Auto** Accident Date: _____ Involved in litigation ☐ Yes ☐ No If Yes, Attorney Name: _____

If **Post-Surgical** date of surgery: _____ Type of Surgery:_____

Other Circimstances:_____

Comments:_____
_____
_____

DESCRIPTION OF PAIN:

____ Intermittent	____Remains Constant	____Increasing	____Decreasing
____ Aching	____ Stabbing	____ Cramping	____ Shooting
____ Burning	____ Numbness	____ Tingling	____ Pins and Needles
____Sharp	____ Throbbing	____ Dull	

Does Pain Radiate? ☐ Yes ☐ No If so, where: _____

What increases the pain? _____

What decreases the pain? _____

Does your pain interfere with: __ Personal Grooming, __ Driving, __Walking, __Work, __Cooking, __Childcare,
(Mark all that apply) __Intercourse, __Sweeping, __Vacuuming, __Leisure Activities, __ Sleep

PATIENT INFORMATION SHEET (2 OR 3)

Have you had any of the following treatments related to your pain? **(*DO NOT LEAVE DATES BLANK*):**

Type of Treatment	Dates of Treatment	Location of Facility That Provided Treatment
__Physical Therapy	Dates:_____	Location:_____
__Occupational Therapy	Dates:_____	Location:_____
__Injectable Therapy	Dates:_____	Location:_____
__ Surgery	Dates:_____	Location:_____
__ Laboratory Testing	Dates:_____	Location:_____
__ Radiology Exams	Dates:_____	Location:_____
__ NCS/EMG	Dates:_____	Location:_____
__ Bracing	Date:_____	Type of Bracing:_____
__Medication Therapy	How Long: _____	Medication Used:_____

MEDICAL HISTORY:

YES	NO	Asthma	YES	NO	Heart Attack
YES	NO	Arthritis	YES	NO	HIV/AIDS
YES	NO	Bronchitis	YES	NO	Kidney Disease
YES	NO	Cancer	YES	NO	Liver Disease
YES	NO	Circulation Problems	YES	NO	Neuropathy
YES	NO	Emphysema	YES	NO	Pacemaker/AICD
YES	NO	Headaches	YES	NO	Rheumatoid Arthritis
YES	NO	Diabetes	YES	NO	Stomach Ulcers
YES	NO	Irritable Bowel	YES	NO	Stroke
YES	NO	Irregular Heartbeats	YES	NO	Seizures
YES	NO	Heart Failure (CHR)	YES	NO	Thyroid Disease
YES	NO	High Blood Pressure	YES	NO	Other:

SURGICAL HISTORY

TYPE OF SURGERY	DATE

FAMILY HISTORY

		CONDITION	LIST ALL MEMBERS OF FAMILY
YES	NO	Cancer	
YES	NO	Diabetes	
YES	NO	Heart Disease	
YES	NO	Hypertension	
YES	NO	Stroke	
YES	NO	Other	

PATIENT INFORMATION SHEET (3 OR 3)

Social History

Do you smoke ☐ Yes ☐ No If yes, at what age did you start:____ How many packs per day:_____

Do you drink alcohol: ☐ Yes ☐ no If yes, how Often? ☐Rarely ☐ Socially ☐ Everyday ☐ Heavily

For men **UNDER** 65 – How many times in the past year have you had 5 or more alcohol drinks in a day? _____

For men **OVER 65** and **WOMEN**, how many times in the past year have you had 4 or more alcohol drinks in a day?_____

Do you currently use illicit drugs or have a history of drug or alcohol rehabilitations: ☐ Yes ☐ No

MEDICATIONS:

MEDICATION	DOSAGE	FREQUENCY

Are you currently taking blood thinners (Coumadin, Aspirin)? ☐ Yes ☐ NO

Are you currently receiving narcotics from any other physician: ☐ Yes ☐ NO

Are you currently under a narcotic agreement with any other physician: ☐ Yes ☐ NO

ALLERGIES:

MEDICATION	DATE OF FIRST OCCURANCE	REACTION

REVIEW OF SYSTEMS:

YES	NO	Fatigue	YES	NO	Back, Hip, Knee, Leg, Foot Pain (Circle all that apply)
YES	NO	Fever	YES	NO	Joint Pain, Stiffness, Swelling (Circle all that apply)
YES	NO	Weight Changes	YES	NO	Bleeding Tendencies
YES	NO	Active Angina / Angina (if yes, circle one)	YES	NO	Clotting Tendency
YES	NO	Chest Pain	YES	NO	Rashes
YES	NO	Palpitations	YES	NO	Wounds
YES	NO	DVT/Blood Clots	YES	NO	Weakness
YES	NO	Frequent Chronic Infections	YES	NO	Numbness
YES	NO	Difficulty Breathing	YES	NO	Bowel Incontinence
YES	NO	Cough / Wheezing	YES	NO	Bladder Incontinence
YES	NO	Abdominal Pain	YES	NO	Eye Pain
YES	NO	Diarrhea	YES	NO	Double Vision/ Blurred Vision (Circle all that apply)
YES	NO	Constipation	YES	NO	Ear Pain
YES	NO	Nausea/Vomiting	YES	NO	Hearing Loss / Ringing in Ears
YES	NO	Loss of Appetite	YES	NO	Heat Intolerance
YES	NO	Anxiety	YES	NO	Frequent or Painful Urination
YES	NO	Depression	YES	NO	Excessive Thirst
YES	NO	Insomnia	YES	NO	Recurrent / Frequent Chronic Infection
YES	NO	Arm, Neck, Hand, Shoulder Pain (Circle all that apply)	Yes	No	TIA

PRC Alliance Pain Relief Center

Date completed_____

PATIENT NAME: _____ DOB:_____	**Never 0**	**Seldom 1**	**Sometime 2**	**Often 3**	**Very Often 4**
How often do you have mood swings?					
How often have your felt a need for higher doses of medication to treat your pain?					
How often have you felt impatient with your doctors?					
How Often have you felt that things are just too overwhelming that you can't handle them?					
How often is there tension in the home?					
How often have you counted your pain pills to see how many are remaining?					
How often have you been concerned that people will judge you for taking pain pills?					
How often do you feel bored?					
How often have you taken more pain medication than you are supposed to?					
How often have you worried about being left alone?					
How often have you felt a craving for medication					
How often have others expressed a concern over your use of medication?					
How often have any of your close friends had a problem with alcohol or drugs?					
How often have you been told you have a bad temper?					
How often have you been consumed with the need to get pain medication?					
How often have you run out of pain medication early					
How often have others kept you from getting what you deserve?					
How often, in your lifetime, have you had legal problems or been arrested?					
How often have you attended and AA or NA meeting?					
How often have you been in an argument that was so out of control that someone got hurt?					
How often have you been sexually abused?					
How often have others suggested that you might have a drug or alcohol problem?					
How often have you borrowed pain medications from family or friends?					
How often have you been treated for a drug or alcohol problem?					
SCORE					

PATIENT SIGNATURE

RELATIONSHIP IF OTHER THAN PATIENT

PRC ALLIANCE PAIN RELIEF CENTER

AKNOWLEDGEMENT OF PREGNANCY TESTING IN
WOMEN OF CHILD-BEARING AGE

Patient Name (Please Print):_____ **DOB**: _____

The use of certain medications during, or just prior to pregnancy may increase the risk of adverse effects upon mother and child. These medications include but are not limited to opiates, benzodiazepines, NSAIDS, antidepressants, hypnotic, anti-convulsants, and antibiotics. Adverse effects include but are not limited to birth defects, increased risk for pre-term labor, increased risk for maternal hypertension, placental defects or complications, maternal withdrawal, neo-natal abstinence syndrome, hemorrhage, and death.

If you are pregnant or plan to become pregnant, please discuss the specific risks of your medication regimen with your provider. Patients who become pregnant will need to have a consultation and clearance by a perinatologist. If clearance is not received, the patient will be weaned from medications until completion of pregnancy. In effort to prevent prolonged fetal exposure to medications, this office will perform pregnancy testing at a minimum of every three months on all women of child bearing age. Specifically, all women between the ages of 10-55 years of age who have not had a total hysterectomy or been post-menopausal for 2 or more years. Surgical sterilization of a patient or spouse i.e. "tubes tied" or "vasectomy"; or current menstruation does not exclude a patient from pregnancy testing. Pregnancy testing may be performed more frequently if a patient reports missing or irregular cycles; or suspected pregnancy. A patient may refuse pregnancy testing, but patients must understand that the provider may elect not to utilize pharmacological management on such patients. Patient also should understand that a negative urine pregnancy test does not guarantee the absence of pregnancy.

I have read, understand and accept the above risks of medication management during or just prior to pregnancy. I have had an opportunity to discuss this with my physician. All my questions and concerns have been addressed to my satisfaction. I consent to medication treatment and routine pregnancy testing. I agree to immediately report a pregnancy or suspected pregnancy to my healthcare provider. Additionally, I will notify my provider if! am planning to attempt to conceive.

_____ _____ _____

Print Signature Date Relationship if Other Than Patient

_____ _____

Physician Signature Witness Signature

PRC ALLIANCE PAIN RELIEF CENTER

PATIENT CONSENT TO LEAVE DETAILED MESSAGE / INFORMATION & HIPAA CONTACTS

Patient Name (Please Print):_____ **DOB**_____

PRC Alliance Pain Relief Centers has adopted a policy that requires our staff to obtain authorization from the patient to leave detailed messages for the patient. This policy is to protect the patient and to also protect our staff from violating patients' confidentiality. If we do not have a signed consent on file, the staff may leave your name and a phone number on an answering machine or with another person answering your telephone.

By completing the consent below, you hereby authorize the staff at PRC Alliance Pain Relief Centers to contact you via telephone and leave their name, doctors name, and any additional information on an answering machine or with a specified individual. Unless notified in writing, this consent will remain in effect permanently.

Regardless of the option that you choose, you may still receive appointment reminders via telephone calls, text messages, or portal messages.

Choose on of the following two options

☐ I DO NOT consent to have detailed messages containing personal health information (PHI) left on my voicemail system.

☐ I give consent to my doctor and /or doctors staff at PRC Alliance Pain Relief Center to leave a voice message regarding treatment, test results or other necessary information.

PRC Alliance Pain Relief Center Associates may leave messages on the following numbers:

Location	Phone Number
Home Voicemail or Answering Machine	
Cell Phone Voicemail	
Work Voicemail	

I give PRC Alliance Associates my permission to discuss my healthcare with the following individuals: (This includes any information about my care, unless otherwise stated).

Full Name	Phone Number

I give PRC Alliance Associates permission to discuss my financial information with:

Full Name	Phone Number

Patient Signature:_____ Date:_____

Print Name if other than patient:_____ Relationship:_____

PRC ALLIANCE PAIN RELIEF CENTER

Assignment of Benefits, Patient Payment Agreement Authorization for Use or Disclosure of Information

Patient Name (Please Print):_____ **DOB**_____

I hereby assign and authorize payment made on my behalf directly to PRC Alliance of the covered insurance benefits, including major medical benefits. I understand that my health insurance provider may not cover part, or all of the medical services rendered, and I fully understand and agree that I am ultimately financially responsible for and agree to pay all charges on my account for any professional services rendered that are not paid by my healthcare coverage. I understand my financial responsibility includes all deductibles, coinsurance, co-payments, payments from insurance companies sent directly to me, and any remaining amount not covered by my insurance. In consideration of the medical services furnished to me, I acknowledge that no guarantees have been made to me as to the results of my appointment(s) or treatment at PRC Alliance, and I hereby agree to pay PRC Alliance any balance due within 90 days from presentation of my bill.

In the event a check I have written for services rendered by PRC Associates fails to clear my bank for any reason, I agree to rectify the situation and bring my account current within two (2) business days and also to pay the additional $35.00 administrative fee to PRC Alliance at that time. If my account should become delinquent and collection efforts become necessary, I agree to pay any reasonable collection or attorney fees incurred.

I have disclosed the names of all my health insurance carriers, and I represent that such healthcare coverage is in full force and effect at this time. If prior authorization, referral, or certification for medical services is required under.my healthcare coverage, I agree to obtain and furnish such authorization, referral, or certification.

I authorize any holder of hospital or medical information to release said information as may be required to determine the benefits, liability, medical insurance coverage, and/or to process claims for payment of medical services rendered. It is expressly understood that this information will only be used for these purposes. I understand that any records or paperwork I give to any staff member of PRC Alliance becomes the property of PRC Alliance and no longer belongs to me.

I agree to promptly notify PRC Associates of any change of address or insurance coverage. I permit PRC Alliance to use my health information and/or to disclose my health information to any third-party payer or to any party involved in my health care. I understand that there is a Notice of Privacy Practices posted in PRC Alliance reception area available for me to read. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I am satisfied that I fully understand this assignment, payment agreement, and privacy disclosure agreement and its significance. A copy of this form shall be considered as valid as the original and remains in effect regardless of mystatus as a patient. I understand I have the right to revoke this consent, in writing, at any time by sending such written notice to my provider(s) at this practice.

_____	_____	_____
Patient Signature	Relationship to Patient	Date Signed

PRC ALLIANCE PAIN RELIEF CENTER

FINANCIAL AGREEMENT

Patient Name (Please Print)_____ DOB _____

Thank you for trusting PRC Alliance to partner in your health care. We are committed to delivering the highest level of care to you and payment of your bill is essential in our ability to offer your medical services. At every step in your treatment, we are willing to assist you in understanding the costs of your care and your related insurance coverage. This financial agreement should answer questions regarding patient and insurance responsibility for services rendered. Please read this agreement, ask us any questions you may have, and sign in the space provided. You will be given a copy of this agreement for your records if requested.

Insurance

Your insurance coverage is a contract between you and the insurance company, and it is your responsibility to know your insurance benefits. As a courtesy, we will bill both your primary and secondary insurance companies. We will submit your claims and assist you in any way we reasonably can to help get your claims processed. In order to do this, we must receive all the information necessary to bill. If the information is not supplied, payment for services will be your responsibility and a deposit will be required with full payment for scheduled treatment payable at the time of service.

Medicare

PRC Associates' Providers participate in the Medicare program. You are responsible for your deductible, co- insurance and non-covered services that are identified as patient responsibility on your Medicare Explanation of Benefits (EOB). We strive to inform our Medicare patients of services that will not be covered. You will be asked to sign an Advanced Beneficiary Notice (ABN), which lists our fees and notifies you of your financial responsibility for certain medical services.

Managed Care

Many patients are enrolled in Managed Care Products. In order for us to obtain referrals and/or pre-authorizations for procedures, it is important that we have your current insurance information. Depending on individual policies, your procedure may not be a covered benefit. It is your responsibility to check for coverage and policy limitations. Please contact your insurance company with questions regarding your coverage.

Patient Responsibility for Payment

You are responsible for any co-payment, co-insurance, deductible or service not covered by your insurance carrier. Payment is due at the time of services. If you do not have insurance, self-pay rates are available and must be paid at the time of services. Patient balances noted on your monthly statement are due within 30 days of receipt. We will bill appropriate insurance if all required information is provided.

Deposits

If insurance co-payment and coverage cannot be verified by the time of service or you have elected a high deductible plan, a deposit and/or payment of estimated billed charges must be received on account before the first date service. If insurance payment results in a credit balance, you will be refunded.

Payment Options

We understand that financial circumstances vary from patient to patient. If you are unable to pay your patient due balance in full, you must call our billing office at **(888) 719-9036** to make payment arrangements. Payment arrangements are payable by cash, check, or credit card. Payment plans must be current to continue treatment in our practice.

Non-Payment

Failure to pay will result in your account being referred to a collection agency, cancellation of any upcoming appointments, and possible discharge from our practice. Once your account is referred to a collection agency, you must contact the collection agency to discuss payment arrangements.

Insufficient Funds

NSF checks will result in a $35 processing fee. I have received this financial policy and understand that regardless of any insurance coverage I may have, I am ultimately responsible for payment of my account balance. I understand that delinquent accounts will be referred to a collection agency. If it becomes necessary to send my account to a collection agency, I agree to pay for all costs and expenses, including reasonable attorney fees. I understand I may be discharged from the practice for non-payment of my account. Upon request I will receive a copy of this financial agreement for my records. I acknowledge that this agreement remains in effect for the duration of my care and for all patients who seek treatment at PRC Associates.

_____	_____	_____
Patient Signature	Relationship to Patient	Date Signed

PRC ALIIANCE PAIN RELIEF CENTER

24 Hour Cancellation and No-Show Fee Policy

Patient Name:_____ **DOB:**_____

Your appointment time is reserved especially for you and each time a patient misses an appointment without providing appropriate notice, another patient is prevented from receiving care. Please contact our office at 386-274-2977 no less than 24 hours prior to your scheduled appointment time if you are unable to keep your appointment,

If you check in for your appointment more than 15 minutes past your scheduled appointment time, you may need to be rescheduled to the next available appointment time and date. Medications will not be provided if you are unable to be seen by your provider.

PRC Associates reserves the right to charge a **$25.00** fee for all missed (No Show) office visit appointments, a **$75.00** fee for all missed (No Show) in office procedure appointments, and **$150** fee for all missed (No Show) Alliance Specialty Surgery Center appointments. This fee is not covered by your insurance carrier and must be paid prior to your next appointment. Multiple “no shows” or same-day cancellations in a six-month period may result in termination from our practice.

We appreciate your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Signature: _____

Printed Name: _____

Date: _____

Relationship if other than patient: _____

PRC ALLIANCE PAIN RELIEF CENTER

TREATMENT AGREEMENT

Patient Name: _____ **DOB:** _____

Because controlled substances have potential for abuse or diversion, a strict set of rules is necessary for your protection and for ours. Review this document carefully and talk to your provider before signing if you have any questions. Your signature on this document indicates that you agree to the following policies and rules of this practice. In order to be eligible to receive controlled substance (opioid) prescriptions from PRC Alliance (PRC), I agree to and understand the following, and know that failure to follow these rules means that I can be discharged from medication management or from PRC Alliance:

I agree to follow a multi-disciplinary approach to my pain. This means that I agree to follow my provider's recommendations for treatment that he or she believes will help my pain, including procedures and other treatments.

I agree to only take opioids which are prescribed by PRC, unless I request permission from my PRC provider. I can receive treatment at urgent care or emergency room but may not fill opioid prescriptions written there.

I agree to take my medications ONLY as prescribed to me by my PRC provider, and will not make a change to the dosage of my medications or to how often I take them without my PRC provider's permission.

I will not take opioids that are not prescribed to me, or share, sell, or trade my prescribed medications with anyone. I agree not to use any illicit drugs while taking these medications.

I agree **not** to drink alcohol while taking these medications. Dangerous side effects, including death, can occur when alcohol is combined with controlled substances.

I agree to attend all PRC appointments, or if the appointment needs to be rescheduled, give at least 24 hours' notice.

I agree to keep all medications in a safe place and away from children.

I agree to unannounced urine or oral fluids drug screening and random pill counts.

I agree to tell my PRC provider of any new medications or changes in medical conditions, and of any side effects I experience from any medications that I take.

I agree to fill all of my PRC prescriptions at the following pharmacy. If I need to change pharmacies, I must notify PRC within one business day of the change. **Pharmacy Name/Address**:

_____

I understand that PRC has a "No Replacement" policy, which means that lost, destroyed, or stolen prescriptions will not be replaced.

I understand that it is my responsibility to know when my medication is due to be refilled, and that prescriptions will NOT be refilled at night, on weekends, or on holidays by the on-call provider. I understand that prescriptions are generally filled at appointments only, and I agree to give at least five working days' notice if I request for a prescription to be refilled without an appointment.

I understand that it is a federal offense to alter a prescription in any way. Alterations to prescriptions are reported to the Florida Pharmacy Board and to law enforcement. If my prescription is found to be altered, I understand that my treatment confidentiality is waived, and legal authorities may be given full access to my records regarding opioids.

I understand that if I do not follow the agreements above, my provider may not continue to provide prescriptions to me and may stop offering medical treatment to me.

I understand that treatment with opioids may be terminated if my pain management specialist determines that they are no longer effective in managing my pain, or if functional activity is not improved, or if! develop a tolerance or loss of effect. 1 agree to follow directions from my pain management specialist to stop and/or slowly lower the opioid medications if my provider thinks it is medically necessary.

I have read, understood, and accept the terms of this agreement. I am signing this form voluntarily and consent to the treatment of my pain with opioid (narcotic) pain medications. I have read and understand the potential risks and benefits and have had the opportunity to have all of my questions answered.

Patient Signature:	Date:

HEADACHE IMPACT QUESTIONNAIRE (HIT-6)

Patient Name:	DOB	Date:

When you have headaches, how often is the pain severe?	Never
	Rarely
	Sometimes
	Very Often
	Always

How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?	Never
	Rarely
	Sometimes
	Very Often
	Always

When you have a headache, how often do you wish you could lie down?	Never
	Rarely
	Sometimes
	Very Often
	Always

In the past four weeks, how often have you felt too tired to do work or daily activities because of your headaches?	Never
	Rarely
	Sometimes
	Very Often
	Always

In the past four weeks, how often have you felt fed up or irritated because of your headaches?	Never
	Rarely
	Sometimes
	Very Often
	Always

In the past four weeks, how often did headaches limit your ability to concentrate on work or daily activities?	Never
	Rarely
	Sometimes
	Very Often
	Always

Score Key:	Never = 6 points each
	Rarely = 8 points each
	Sometimes = 10 points each
	Very Often = 11 points each
	Always = 13 points each

PRC ALLIANCE PAIN RELIEF CENTER

Informed Consent to Treat with Opioid Pain Medications

Patient Name (Please Print): _____ DOB_____

You should read this informed consent carefully, ask questions if you have them, and review it with your healthcare provider before you sign it. The purpose of this document is to give you information about the medications you will be taking for pain management. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

I understand that my provider is prescribing opioid medications to me for the treatment of my symptomatic pain. I understand and agree that my provider may adjust my pain medications according to my pain level at subsequent visits as warranted.

RISKS

Opioids or other controlled substances may be prescribed in the treatment of chronic and acute pain. With any medications there are potential risks and side effects including the risk of addiction.

I understand not to be involved in any activity that may be dangerous to me or someone else if! feel drowsy or am not thinking clearly and even if! do not notice it, my reflexes and reaction time might be slowed. Such activities include, but not limited to making important decisions both personal and work related, using heavy equipment, operating a motor vehicle, working in unprotected heights, or being responsible for another individual who is unable to care for themselves. In addition, the following is a general list of potential risks of treating pain with controlled substances:

Itching

Constipation and/or difficulty urinating
Decreased sexual function or desire
Confusion or decreased clarity in thinking or ability
Decreased appetite
Nausea, vomiting and Dizziness
Decreased rate of breathing
Increased Sleepiness or Drowsiness
Slowing of reflexes and reaction time and/or problems with Coordination or balance
Children born to mother taking opioids are usually physically dependent on the drug at birth
Opioid use is not generally associated with risk of birth defects

FEMALE PATIENTS of childbearing years MUST notify your pain management specialist if you are pregnant or plan to become pregnant during your treatment at PRC Alliance. It is recommended to use appropriate measures to prevent pregnancy during your treatment with opioids. If you become pregnant during the use of opioids, you must notify your pain management specialist immediately as well as your obstetric and/or primary care provider.

MALE PATIENTS need to be aware that chronic opioid use has been associated with low testosterone levels and may affect mood, stamina, sexual desire and physical and sexual performance. It is recommended that you see your primary care provider to perform routine testing for normal levels of testosterone.

OVERDOSE: Overdose can result from taking medication(s) other than how they have been prescribed, which can lead to respiratory arrest and/or death.

PHYSICAL DEPENDENCY

Physical dependence is a normal and expected result of using opioid medication and can result within a few weeks of starting opioid therapy. Abruptly stopping, marked decreasing or reversal of the drug may lead to withdrawal syndrome. Potential symptoms of withdrawal are diarrhea, abdominal cramping, nausea, vomiting, change in heart rate and blood pressure, large pupils, "goose flesh", sweating, anxiety, irritability, shaking, insomnia, achy muscles, yawning, watery eyes, runny nose, hot and cold flashes and craving for the medication. Although withdrawal syndrome is uncomfortable it is not life threatening. Certain medications such as nalbuphine (Nubain), pentazocine (Talwin), buprenorphine (Buprenex) and butorphanol (Stadol) may reverse the action of the opioid (narcotic) medication being used for pain control. Taking any of these medications while talking opioid pain medications can cause a withdrawal syndrome.

PSYCHOLOGICAL DEPENDENCY/ADDICTION

Psychological dependence (addiction) is recognized when the patient abuses the drug to obtain mental numbness or euphoria; shows a drug craving behavior or "doctor shopping"; using a medication even if it causes harm or a decreased quality of life; when drug use is escalated without correlation with the pain relief or when the patient shows a manipulative attitude toward the pain management specialist in order to obtain the drug.

TOLERANCE

Tolerance is the need for a higher opioid dose to maintain the same pain control. Increasing the medication may not always help and may cause unacceptable side effects. A better option is to switch to a different opioid medication or can be managed by adding a second different drug to the opioid therapy. If tolerance to the opioid medication is unmanageable the opioid medication will be tapered and discontinued.

BENEFITS

Opioid therapy can be a very beneficial treatment. The following is a general list of benefits: Reduced pain, improve pain-related dysfunction, Improved quality of life

TREATMENT ALTERNATIVES

The following is a general list of treatment alternatives to opioid therapy and may be used in conjunction with this therapy or as an alternative:

Non-narcotic medications NSAIDS
Topical Analgesics Injection Therapy
Physical/Occupational Therapy Exercise
Behavioral Assessment No treatment

I have read this form or have had it read to me and am signing this form voluntarily. I have had a chance to have all of my questions answered in regard to this treatment including the risks and benefits and agree to the use of opioids as part of my treatment for chronic pain.

_____ _____

Patient's Printed Name and Date of Birth Patient's Signature and Date Signed

_____ _____

Pain Management Specialist Signature Witness

PRC ALLIANCE PAIN RELIEF CENTER

Notice of Privacy Practices

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.

Patient Name:_____ DOB:_____

At PRC Alliance Pain Relief Center "PRC", which includes other independent healthcare providers, we understand that your medical information about you and your health is personal. Our practice is committed to protecting your medical information. We are required by federal and state laws to maintain the privacy of your Protected Health Information (PHI) and to give you this notice explaining our privacy practices with regard to your information. This notice explains your rights and our legal obligations regarding the privacy of your PHI.

Protected Health Information is information that individually identifies you. It may be used and disclosed by your physician, our office staff, another healthcare provider, your health plan, your employer or a healthcare clearing house that relates to (1) past, present or future physical conditions, (2) the provision of healthcare to you, or (3) the past, present or future payment for your health care.

How We May Use and Disclose Your Protected Health Information:

I. Treatment: Your PHI may be provided to a physician or healthcare provider to whom you have been referred, to ensure they have the necessary information to diagnose, treat or provide a service.

2. Payment: Your PHI may be used and disclosed to enable us to bill and either collect payment from you, a health plan or a third party for the treatment and services you receive from us. As an example, we may need to give your health plan information of your treatment in order for your health plan to agree to payment for that treatment.

3. Health Care Operations: We may use and disclose your PHI in order to support the business activities of your physician's office. The activities include, but are not limited to, the evaluation of our team members in caring for you, quality assessment, the disclosure of information to physicians, nurses, medical technicians. medical students and other authorized personnel for education and learning purposes.

4. Appointment reminders/Treatment Alternatives/ Health-Related Services: We may use and disclose your PHI to contact you to remind you that you have a scheduled medical appointment or to advise you of treatment options or alternatives or health related benefits and services which may be of interest to you.

5. As required by Law: We will disclose your PHI about you when required to do so by international, federal, state or local law. Examples include:

- Public health activities including reporting of certain communicable diseases,
- Workers' compensation or similar programs as required by law,
- Authorities when we suspect abuse, neglect, or domestic violence,

- Health oversight agencies,
- For certain judicial and administrative proceedings pursuant to an administrative order,
- Law enforcement purposes,
- Medical examiner, coroner, or funeral director,
- The facilitation of organ, eye, or tissue donation if you are an organ donor,
- To avert a serious threat to your health and safety or that of others,
- For governmental purposes such as military service or for national security; and
- In the event of an emergency or for disaster relief

6. Marketing & any purposes which require the sale of your Information: These disclosures require your written authorization.

7. Business Associates: We may share your PHI with other individuals or companies that perform various
· activities for, or on behalf of, our office such as after-hours telephone answering, quality assurance, or clinic research. Our Business Associates agree to protect the privacy of your information.

8. Any other uses and Disclosures not recorded in this Notice will be made only with your written authorization. You may revoke the authorization at any time by submitting a written revocation and we will no longer disclose your PHI, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF PRC ALLIANCE PAIN RELIEF CENTER. THE INFORMATION CONTAINED IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

1. The Right to Inspect and Copy: Under federal law you have the right to inspect and copy your PHI and PRC Associates has up to 30 days to make your PHI available to you; fees may apply.

2. The Right to an Electronic Copy of Electronic Medical Records: You have the right to request that an electronic copy of your PHI be given to you or transmitted to your designated officer. We will make every effort to provide the electronic copy in the format you request, however, if it is not readily producible by us we will provide it in either our standard format or in hard copy form (fee may apply).

3. Restrictions on Use and Disclosure: You have the right to request a restriction or limitation on the PHI we use or\disclose for treatment, payment or health care operations. You may ask us not to use or disclose any part of your PHI and by laws we must comply when the PHI pertains solely to health care item or service which the health care provider involved has been paid out of pocket in full. Your request must be made in writing to our HIPAA Compliance Officer with specific address noted below. If we agree to the restriction, we may only be in violation of the restriction for emergency treatment purposes. By law, you may not request we restrict the disclosure of your PHI for treatment purposes.

4. The Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured PHI.

5. The Right to Request Amendments: If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. A request and the reason for the requested amendment must be in writing to the HIPAA Compliance Officer at the information at the end of this Notice. In certain cases, we may deny your request. If we deny your request, 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 a copy.

6. The Right to an Accounting of Disclosures: You have the right to receive an accounting of all disclosures: pursuant to an authorization, for purposes of treatment, payment. healthcare operations; required by law, that occurred six years prior to the date of the request. Your request must be made in writing and you must indicate in what form you want the list, for example on paper or electronically. The first accounting of disclosures in any 12-month period will be free. Any additional requests within that same period we may charge reasonable costs. You may withdraw or modify your request before the costs are incurred.

7. The Right to Request Confidential Communications: You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you on a specific telephone number. Your request must be made in writing with specific instructions on how and where we contact you. We will accommodate all reasonable requests and will not ask the reason for your request.

8. Copy of Notice: You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.

If you have questions about this notice, please contact PRC Associates' Privacy Officer at 18201 Von Karman Ave Ste 600, Irvine, CA 92612 or (949) 242-5854 If you feel your privacy rights have been violated, you have the right to file a written complaint with our office. You may also file a complaint with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint.

I have received a copy of this office's Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, and protected.

Patient Signature: _____ Date: _____

Printed name if other than patient: _____ Relationship: _____