Pain Medicine Associates
your life, your health, pain free

Patient Information

First Name:	**Middle Name**:	**Last Name**:
DOB:	**Sex:** ☐**Male** ☐**Female**	**SSN:**
Ethnicity: ☐**Not Hispanic/Latino**	☐**Hispanic/Latino**	
Race: ☐**African American** ☐**Asian** ☐**White** ☐**American Indian/Alaska Native** ☐**Other**:		
Primary Language:		
Marital Status: ☐**Married** ☐**Single** ☐**Widowed** ☐**Divorced** ☐**Domestic Partner**		
Address:		
City:	**State:**	**Zip:**
Primary Phone:	**Cell Phone:**	**Home Phone:**
Work Phone:	**E-mail:**	

Employment Status: ☐**Employed** ☐**Retired** ☐**Student** ☐**Un-Employed**		
Employer:	**Occupation:**	**Employer Phone:**
Employer Address:		

Emergency Contact Full Name:	**Relationship:**
Primary Phone:	**Work Phone:**

Is the Patient Financially Responsible? ☐**Yes** ☐**No** **If No, Please Complete this Section**		
Relationship:	**Sex:** ☐**Male** ☐**Female**	**SSN:**
First Name:	**Middle Name**:	**Last Name**:
Address:		
City:	**State:**	**Zip:**
Primary Phone:	**Cell Phone:**	**Home Phone:**
Employer:	**Occupation:**	**Employer Phone:**
Employer Address:		

Is the Reason for Your Visit the Result of An Accident? ☐**Yes** ☐**No?**
If *Yes*, Please Complete this Section
Which Type of Accident? ☐**Workman's Comp** ☐**Automobile** ☐**Other:**
Date of Accident: **Claim #:** **Claim Adjuster:**

Insurance Company:		**Insured DOB:**
Insured/Card Holder's Name:		**Relationship**:
ID#:	**Group #:**	**Phone**:
Secondary Insurance Company:		**Insured DOB:**
Insured/Card Holder's Name:		**Relationship**:
ID#:	**Group #:**	**Phone**:

Patient Signature:_____ **Date:** / /

Pain Medicine Associates
your life, your health, pain free

TELL US ABOUT YOUR MOST SIGNIFICANT PROBLEM

How did you hear about us? ☐**Friend** ☐**Internet** ☐**Insurance** ☐**Advertisement** ☐**Other:** _____

Where is your pain located? Please list all that apply

How long has your pain been occurring?

Is your pain constant or Intermittent?

How did your pain first start: (CIRCLE ALL THAT APPLY)

Lifting Twisting Suddenly Gradually Fall Bending While Exercising Auto Accident

Injured at work Pulling Sports Hit From Behind No Apparent Cause

Other: _____

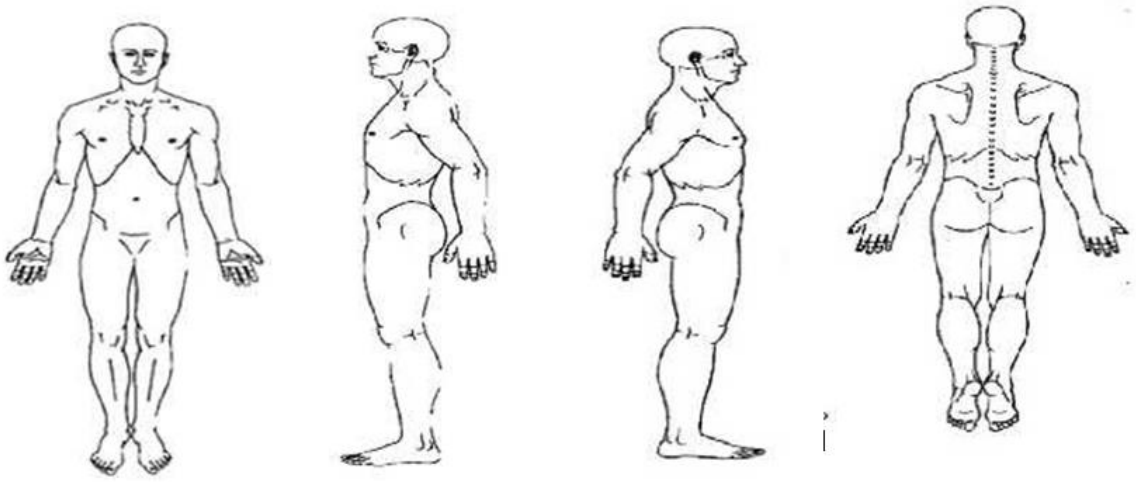
Circle all that apply to the type of pain you are feeling? Circle All That Apply

Achy Burning Dull Sharp Shooting Stabbing Tingling

Circle anything that makes the pain worse? Circle All that Apply.

Activities Bending Stretching Sitting Standing Twisting Walking

Where is your pain? Where does it spread to? Please shade where your pain is located



Circle any of the following that relieve the pain. Circle All that Apply.

Heat/ice packs Laying Down Pain Medication Rest Standing Sitting Stretching

What is your pain on a scale of 0-10 on TODAY?	**What is your pain on a scale of 1-10 on your BEST day**?	**What is your pain on a scale of 1-10 on the WORST day?**
_____	_____	_____

Patient Initials:_____ **Date:** / /

Pain Medicine Associates
your life, your health, pain free

Have you had any prior treatment for this condition? Circle All that Apply

Physical Therapy Spine Injection Anti-Inflammatory Medications Pain Medications

Bed Rest TENS unit Previous Pain Management Doctor

What recent studies/imaging have you had relating to this condition? Please Circle all that Apply.

X Ray MRI CT Scan EMG (Needle testing of Muscles) Nerve Conduction Study Discogram

Do you have a Primary Care provider? If yes, please list here.

Any other Healthcare Providers we should know about? Please list here.

_____ _____

_____ _____

PAST MEDICAL, SURGICAL, FAMILY MEDICATION AND SOCIAL HISTORY

Have you had any Sports Injuries? If yes when?

Have you ever had any broken bones? If yes when?
What bone/s?

Have you ever been disabled?

Are you currently disabled? IF yes what type? **SSD SSI**

MUSCULOSKELETAL: Fibromyalgia Osteoarthritis Osteoporosis Rheumatoid Arthritis

CARDIAC: Cardiac Pacemaker Cardiac Stent Coronary Artery Disease DVT (blood clot)
Anemia CHF (heart Failure) Heart Attack if yes, when? Hypertension Peripheral Vascular

ENDOCRINE/Metabolic: Diabetes Mellitus Immune Disorder Thyroid Disorder

LIVER DISEASE: Hepatitis (Type: ____)

NEOPLASM: Cancer Tumor – Type_____ | **INFECTIOUS DISEASE:** HIV Positive

PSYCHIATRIC: A.D.D. Anxiety Depression PTSD

RESPIRATORY: Asthma COPD/Emphysema Lung Disease PE Tuberculosis

UROLOGY/NEPHROLOGY: Kidney Disease Kidney Stone Prostate Issues

Patient Initials:_____ **Date: / /**

Pain Medicine Associates
your life, your health, pain free

PAST SURGICAL HISTORY: Please list any major Surgical Procedures and Dates	ALLERGIES: Drug/Food/Environmental
_____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____

FAMILY HISTORY: Circle All that Apply

Family History of Alcoholism Family History of Drug Addiction Heart Disease Hypertension

Stroke Diabetes Bleeding Disorder Rheumatoid Arthritis Back/Neck Osteoarthritis Asthma
Other: _____

SOCIAL HISTORY: Please answer the following about yourself

Do you Drink Alcohol: If yes #____ drinks per day/week/month
Do you have a history of heavy alcohol use or Alcoholism?

Do you have a history of drug addiction?
Do you use any street drugs? IF yes, what? Marijuana, cocaine, other: _____

Do you Smoke: If yes what? Cigar, Pipes, Cigarettes, e-Cigarettes #_____packs per day

FOR FEMALES OF CHILDBEARING AGE ONLY Many pain medication, X Rays and injections are potentially dangerous to an unborn baby. Is there any chance you may be pregnant? YES NO

MEDIC ATIONS: PLEASE LIST ALL MEDICATION CURRENTLY PRESCRIBED OR OVER THE COUNTER

Medication	Dosage	Prescribing Physician	For Which Condition

Patient Initials:_____ **Date: / /**

Pain Medicine Associates
your life, your health, pain free

Review of Symptoms: Have you recently experienced any of the following? Circle or mark answers below		
General/Constitutional ☐Fevers /Chills ☐Infection anywhere ☐Sleep Problems	**Cardiovascular** ☐Chest Pain (any) ☐Rapid Heartbeat ☐Heart murmur	**Respiratory** ☐Shortness of Breath ☐Wheezing ☐Sleep Apnea/C-PAP/Oxygen
Gastrointestinal ☐Nausea / Vomiting ☐Constipation ☐Stomach/Abdominal Pain	**Genitourinary** ☐Kidney stone pain ☐Painful Urination ☐Blood in Urine	**Neurological** ☐ Numbness ☐ Tingling ☐ Incontinence of bladder
Muscle/Bones/ Joints ☐Muscle Spasms ☐Muscle weakness ☐Joint Pain/ extremity	**Endocrine** ☐Severe Thirst ☐Severe Fatigue ☐Decreased Sex Drive	**Psychiatric** ☐ Anxiety nervousness ☐ Feeling Sad /Depressed ☐ Suicidal Ideation ☐ Addiction to anything
Hematological ☐Easy bleeding bruising ☐Bleeding disorder/problem ☐Lymph node enlargement	**Allergy / Immunology** ☐Shellfish Allergy ☐Environmental Allergies ☐HIV	**Cancer** ☐Prostate/Colon ☐Breast ☐Lung ☐Other _____

Patient Initials:_____ **Date:** / /

Pain Medicine Associates
your life, your health, pain free

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____

DOB:_____/_____/_____ Phone Number: _____

I authorize the release of my medical records to Physician Partners of America (PPOA) for review and continuation of my medical care. I authorize the following physician offices, clinics, legal offices, diagnostic centers, and medical providers to provide copies of my health records to:

Persons/organizations receiving:

(List all facilities, clinics, and offices from which information may be requested)

PHYSICIAN OFFICES (please list all physicians you have seen in the past two years)

Physician Name	Address	Phone Number

HOSPITAL/OTHER FACILITIES (surgeries/procedures, radiology reports, laboratory results)

Facility Name	Address	Phone Number

Restrictions: _____ there are NO restrictions to the information that can be released
_____ the following information CAN NOT be released:
_____

DURATION: This Authorization will remain in effect: (please check selection):
_____ from the date of this Authorization until ____/_____/_____
_____ until the provider fulfill this Authorization request
_____ until the following event occurs: _____

Date:_____/_____/_____Patient/Guardian Signature _____

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Physician Partners of America (hereinafter "PPOA") and/or its affiliated entities, for any charges not covered by my healthcare benefits. It is my responsibility to notify PPOA of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill and/or balance of the bill as determined by PPOA and/or my healthcare insurer, if the submitted claims or any part of the claim are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained above, for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare if I am a Medicare beneficiary, to PPOA for all covered medical services and supplies provided to me during all courses of treatment. This includes care provided by PPOA and/or its affiliated entities or otherwise at its discretion. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with PPOA, which will authorize and allow for direct payment to PPOA, of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by PPOA.

Ownership Disclosure

I understand that PPOA is a physician-owned medical practice comprised of the offices of primary care providers, specialty care providers, and associated ancillary services. These ancillaries include, but may not be limited to, laboratory, pathology, radiology/diagnostic, physical therapy, pharmacy, and ambulatory surgery center services. During the course of my care, I may be referred to one or more of these ancillary departments. I have the right to choose where to receive these services, and I understand that I am not obligated to receive these services at a PPOA ancillary department.

_____	_____
Printed Name of Patient	Name of Guardian/Personal Representative
_____	_____
Signature of Patient	Signature of Guardian or Personal Representative

Patient Initials:_____ **Date: / /**

Pain Medicine Associates
your life, your health, pain free

Counseling Patients on Overdose Risk and Response

Empirical evidence has shown that lay persons can be trained to recognize the signs of an opiate overdose and to safely administer naloxone, an opiate antagonist, programs that have trained lay persons in naloxone administration have reported more than 10,000 overdose reversals.

It is important to educate patients and family/caregivers about the danger signs of the respiratory depression, everyone in the household should know to summon medical help immediately if a person demonstrates any of the following signs while on opioids:

Snoring heavily and cannot be awakened.
Periods of ataxic (irregular) or other sleep-disordered breathing
Having trouble breathing
Exhibiting extreme drowsiness and slow breathing
Having slow, shallow breathing with little chest movement or no breathing
Having an increased or decreased heartbeat
Feeling faint, very dizzy, confused or has heart palpitations.
Blue skin/lips
Non-responsive to painful stimulation

Please note: All patients must sign this form even if no opioid medication is needed or desired currently. This is for your understanding only. Furthermore, in case of emergency or surgery this allows us to be your primary pain medication prescriber.

Patient Initials:_____ **Date: / /**

Pain Medicine Associates
your life, your health, pain free

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.

SOAPP®-R ***Source: http://www.opioidrisk.com/node/1209***	**Patient Score: _____** **Tech Initials: _____**	**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?		☐	☐	☐	☐	☐
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?		☐	☐	☐	☐	☐

Has any relative had a problem with the following? Circle Y/N for each.

— Alcohol? Y / N
— Addiction? Y / N
— Mental Illness? Y / N

Patient Initials:_____ **Date: / /**

Pain Medicine Associates
your life, your health, pain free

Consent to Receive Text Message Appointment Reminders

I hereby authorize Physician Partners of America (PPOA), Pain Relief Group its affiliates, and vendors who actively participate in my care to contact me by automated SMS text message, solely for appointment reminders including details surrounding appointment.

I understand that message/data rates may apply to messages sent by PPOA, Pain Relief Centers or its affiliates under my cell phone plan.

My text/mobile number is: (___) _____ Patient Initials _____

I know that I am under no obligation to authorize PPOA, Pain Relief Group its affiliates, or vendors who actively participate in my care to send me text messages. I may opt out of receiving these communications at any time by calling the Services desk at 1-800-400-PPOA (7762) or by typing STOP.

I understand that text messaging is not a secure form of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include your first name, date and time of your appointment, name of physician, and physician phone number, or other pertinent information.

Name: _____

Signature: _____ Date: _____

By signing below, I authorize my doctor and staff members to access my prescribed medication list through the pharmacy database, which will help my provider to deliver comprehensive care.

Signature: _____

Date: _____ Date of Birth: _____

Pain Medicine Associates
your life, your health, pain free

Opioid Risk Tool (ORT)

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

MARK EACH BOX THAT APPLIES	FEMALE	MALE
FAMILY HISTORY OF SUBSTANCE ABUSE		
Alcohol	☐ 1	☐ 3
Illegal drugs	☐ 2	☐ 3
Rx drugs	☐ 4	☐ 4
PERSONAL HISTORY OF SUBSTANCE ABUSE		
Alcohol	☐ 3	☐ 3
Illegal drugs	☐ 4	☐ 4
Rx drugs	☐ 5	☐ 5
AGE BETWEEN 16–45 YEARS	☐ 1	☐ 1
HISTORY OF PREADOLESCENT SEXUAL ABUSE	☐ 3	☐ 0
PSYCHOLOGIC DISEASE		
ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
SCORING TOTALS		

Patient Initials:_____ **Date:** / /

Pain Medicine Associates
your life, your health, pain free

Opiate Agreement

I, _____, am requesting treatment with opiate pain medication(s) because other therapies, treatments, and/or medication(s) that I have previously received and had not provided me with adequate relief of pain. I understand:

- That it is unlikely that any medication(s) will completely remove or eliminate my pain.
- Opiate pain medication(s) will be prescribed for me for humane reasons as long as my pain continues at the present level or intensity, provided that I follow all terms of this agreement/ Agreement.

My provider has discussed potential long-term opiate therapy with me in detail and I understand some of the possible complications that may occur are:

- Chemical/Physical dependence and addiction
- Severe constipation which could require medical Treatment difficulty with urination.
- Drowsiness
- Nausea
- Itching
- Slow breathing or respiration.
- Reduced or absent sexual desire and/or function
- Coma
- Organ damage, failure; or death

Opioids (narcotics) are used for the treatment of moderate to severe pain. Our goal is to relieve distressing pain, with minimal side effects, with improved quality of life. It is our job to continually re-evaluate your pain experience and respond to unrelieved pain.

1. **No** other pain medications are to be taken unless discussed first with a provider at Pain Medicine Associates, INC (An Affiliate of Physician Partners of America). _____ (Initials)
2. **No** increase in medication will be made without the approval of Pain Medicine Associates, INC (An Affiliate of Physician Partners of America). _____ (Initials)
3. I will not request opioids or any other medicine from prescribers other than from Pain Medicine Associates, INC (An Affiliate of Physician Partners of America). _____ (Initials)
4. I consent to random drug testing. _____ (Initials)
5. I will keep my schedule appointments and/or cancel my appointment a minimum of 24-hours to my scheduled appointment. _____ (Initials)
6. I understand that the reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program. _____ (Initials)
7. I realize that all the medications have potential side effects and I will have the recommended laboratory studies required to keep the regimen as safe as possible. _____ (Initials)
8. I realize that it is my responsibility to keep myself and other from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have not used any medication for at least four days. _____ (Initials)
9. I will not use any illegal controlled substance, including marijuana, cocaine, etc. _____ (Initials)
10. I will not share, sell, or trade my medication for money, goods, or services. _____ (Initials)
11. I understand and acknowledge that I will not consume any alcohol beverages while on narcotic medications. _____ (Initials)
12. I understand that any need for medication adjustments or changes, will require scheduling an appointment in the office. _____ (Initials)

Patient Initials:_____ **Date: / /**

13. I will not attempt to get my pain medication from any other health care provider without telling them that I am taking pain medication prescribed by the Doctor. I understand it is against the law to do so, if my primary care provider is willing to prescribe my medication, the Doctor will have to approve the arrangement to make sure there is no duplication. _____ (Initials)
14. I will safeguard my medication from loss or theft and agree that the consequences of my failure to do is that I will be without my prescribed medication for a period of time. _____ (Initials)
15. I agree to use _____ Pharmacy, located at _____, telephone number _____, for all my pain mediation, and advise my new pharmacy of any prior pharmacy's address and telephone number. _____ (Initials)
16. I agree to waive any applicable privilege or right of privacy of confidentiality with respect to the prescribing of my pain medication. I authorize the Doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the California Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication, I authorize the Doctor to provide a copy of this agreement to the pharmacy. _____ (Initials)
17. I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in me being without medication for a period of time. _____ (Initials)
18. I understand that my pain treatment may be stopped if any of the following occur. _____(Initials)

If the practitioner feels that opioids are not effective for my pain or my functional activity is not improved.

A. I give, sell, or misuse the drug.
B. I develop rapid tolerance or loss of effect from this treatment.
C. I develop side effects that are significant in the view of the practitioners.
D. I obtain opioids from sources other than Pain Medicine Associates, Inc.

19. If we choose to discontinue your opioids, we will generally lower the dose slowly over several days.
20. I understand medications will be refilled in a timely manner as long as the pharmacy or patient calls us at least **72 hours BEFORE** you run out of your medication. Weekends and after hour refills will not be filled on a routine basis under any circumstances. _____ (Initials)
21. I understand that if I have any questions or concerns regarding my pain treatment that I will call **Pain Medicine Associates, Inc.**, Monday through Friday, from 9:00am – 4:30pm. _____ (Initials)

Doctor and Patient agree that this Agreement is essential to the Doctor's ability to treat the patient's pain effectively and that failure of the patient to abide by the terms of this Agreement may results in the withdrawal of all prescribed medication by the Doctor and the termination of the Doctor/Patient relationship.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Pain Medicine Associates
your life, your health, pain free

Acknowledgement of Receipt of Notice of Privacy Practices

· The law requires that we ask you to state in writing that you received the notice. However, you are not required to sign the "Acknowledgement of Receipt of the Notice."

· Signing does not mean that you have agreed to any special uses or disclosures (sharing) of your health records.

· Refusing to sign the acknowledgement does not prevent a provider or plan from using or disclosing health information as HIPAA permits.

· If you refuse to sign the acknowledgement, the provider must keep a record of this fact.

Patient Name: _____ Date: _____

Patient Signature: ----------

For Office Use Only

If Patient refused to sign this "acknowledgement of receipt of the notice," please indicate reason for not signing:

_____

Patient Initials:_____ **Date: / /**

Pain Medicine Associates
your life, your health, pain free

Physician Partners of America

504 N Reo Street, Tampa FL 33609
https://www.physicianpartnersofamerica.com/
813-549-2134 ext 2013
cpate@physicianpartnersoa.com

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➢ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➢ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➢ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Patient Initials:_____ **Date: / /**

Pain Medicine Associates
your life, your health, pain free

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Patient Initials:_____ **Date:** / /

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

Patient Initials:_____ **Date:** / /

Pain Medicine Associates
your life, your health, pain free

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We do not create or maintain psychotherapy notes at this practice.

Patient Initials:_____ **Date:** / /

Pain Medicine Associates
your life, your health, pain free

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This notice was revised and is effective as of January 1, 2023.

Carl Pate, Jr., Chief Compliance & Privacy Officer
813-549-2134 ext 2013
cpate@physicianpartnersoa.com

Physician Partners of America

Patient Initials:_____ **Date: / /**