OMEGA PAIN MANAGEMENT
Igor Smelyansky, MD
6348 Lonas Spring Dr, Knoxville, TN 37909
Ph: (865) 337-5137
Fax: (888) 839-6922

TO OUR PATIENTS

Thank you for choosing Omega Pain Management. Please complete the entire packet **PRIOR** to arrival for your appointment. This information is vital to our plan of care for you. If you need assistance completing these forms, please arrive **AT LEAST 1 HOUR** prior to your appointment and promptly notify our staff for assistance.

YOU MUST BRING THE FOLLOWING ITEMS WITH YOU TO YOUR APPOINTMENT:

- **Photo Identification (must be a CURRENT TN ID OR LICENSE)**
- **ALL insurance cards**
- **Completed New Patient Packet**
- **Current List of Medications**
- **Most Recent CT, MRI, X-Ray, Etc. (NO DISCS, PAPER REPORTs ONLY)**

*****IMPORTANT*****

YOU ARE RESPONSIBLE FOR PROVIDING US WITH YOUR MOST RECENT CT, MRI, OR X-RAY REPORT! FAILURE TO PROVIDE THIS AT YOUR APPOINTMENT WILL RESULT IN MEDICATION NOT BEING PRESCRIBED.

Failure to bring any of these items WILL result in your appointment being rescheduled.

All patients are subject to random urine drug screens in the office at any time.

This practice utilizes the services of specially trained NURSE PRACTITIONERS. Most of your follow ups will be scheduled with one of them.

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PATIENT REGISTRATION FORM

Patient Name: _____ Date: ___/___/____

Date of Birth: ___/___/_____ Age: ____ SS#: ____-____-____ Sex: ____ Marital Status: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home #:_____ Cell #: _____ Email: _____

Preferred Contact Method: Home/Cell/Email May we contact you by phone / text / email / portal? Yes/No

Race: ☐ American Indian / Alaskan ☐ Asian ☐ Black / African American ☐ Native / Hawaiian / Other Pacific Islander ☐ White ☐ Other ☐ Prefer not to answer

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Prefer not to answer

Employer Name: _____

Employer Address: _____ Employer Phone #: _____

Primary Care Physician: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

INSURANCE INFORMATION

Primary Insurance: _____ Member ID/Group #: _____/_____

Policy Holders Name: _____ Relationship: _____

Policy Holders SS#: _____-_____-_____ Date of Birth: _____/_____/_____

Secondary Insurance: _____ Member ID/Group #: _____/_____

Policy Holders Name: _____ Relationship: _____

Policy Holders SS#: _____-_____-_____ Date of Birth: _____/_____/_____

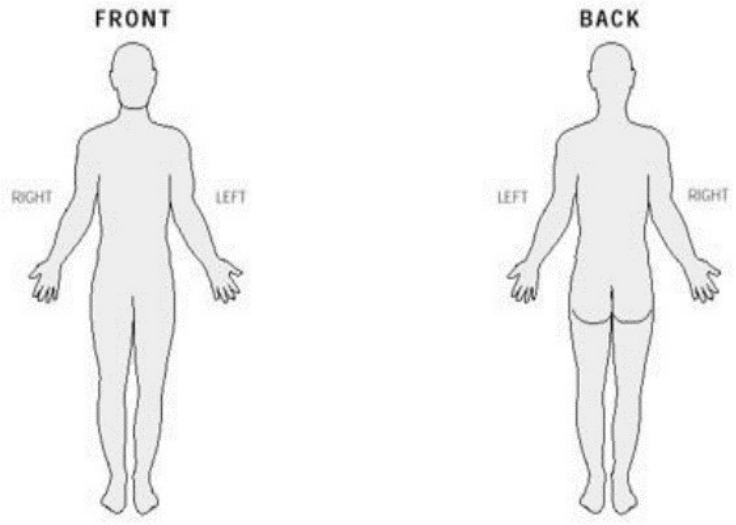
New Patient History

Patient Name:_____ DOB _____ ☐Male ☐Female

Referring Provider Name:_____ Phone Number: _____

Primary Care Provider Name:_____ Phone Number:_____

On the diagram, please **indicate location** of your pain:



Where is your pain? (neck, lower back, etc)

_____

_____

When did your pain begin?

Month:_____ Year :_____

Please describe **in chronological order** what caused your pain and all the events until now.

_____

_____

_____

_____

_____

_____

_____

_____

_____

If your pain level was 50% less tomorrow, what would you be able to do? _____

_____

_____

Have you undergone a **Spinal Cord Stimulator Implant** ? ☐ Yes ☐ No (If yes, date implanted): _____

☐ Medtronics ☐Nevro ☐Boston Scientific ☐Abbott Is the implant still functioning? ☐ Yes ☐ No

Patient Name: _____ DOB: _____/_____/_____

How often is your pain present? Constantly, Rarely, Frequently, Intermittently, Occasionally

Please describe your pain: mild, moderate, severe, sharp, dull, burning, throbbing, shooting, aching, numbness, tingling, etc_____

What makes your pain worse: _____

What makes your pain better: _____

Average Pain Score WITHOUT MEDS (0-10 scale) _____ Average Score WITH MEDS (0-10 scale)____

Have you had a **recent MRI, CT scan, X-ray, or other imaging**? ☐ Yes ☐ No

If yes, list the body part, date and facility where performed: _____

_____

_____

Recent **Injections**? ☐ Yes ☐ No If yes, list type of injection, body part, date, facility and date if helpful:

_____

Have you tried **Physical Therapy**? ☐ Yes ☐ No (If yes, on what body part + when + where?): _____

☐ Massage ☐Acupuncture ☐Home exercises ☐Heat/Ice ☐Stretching ☐TENS unit

Please list **CURRENT MEDICATIONS** (**or attach a list** to paperwork):

Medication Name	**Dose**	**Frequency**	**Medication Name**	**Dose**	**Frequency**

Please list **ALL MEDICATION ALLERGIES**_____

Do you have **any IV DYE or IODINE Allergies** ? _____

*****ARE YOU TAKING ANY BLOOD THINNERS? ***** Please circle: **Coumadin/ Warfarin,** Plavix, Effient, Xarelto, Pradaxa, etc _____

Patient Name: _____ DOB: _____/_____/_____

Previously Tried Medications

Medication Name:	TRIED (place a checkmark)	Did it help?: (please circle)
☐ Tylenol #3, Tylenol #4 (with codeine)		Yes / No
☐ Tramadol/ Ultram, Ultracet		Yes / No
☐ Hydrocodone / Lorcet, Lortab, Norco		Yes / No
☐ Morphine Sulfate / Avinza, Kadian, MS Contin		Yes / No
☐ Oxycodone/ Percocet, Endocet		Yes / No
☐ OxyContin/ Xtampza		Yes / No
☐ Oxymorphone/ Opana, Opana ER		Yes / No
☐ Hydromorphone / Dilaudid, Exalgo ER		Yes / No
☐ Tapentadol / Nucynta, Nucynta ER		Yes / No
☐ Fentanyl / Duragesic patches		Yes / No
☐ Butrans patches		Yes / No
☐ Methadone (if yes, when and why_____)		Yes / No
☐ Suboxone (if yes, when and why_____)		Yes / No
☐ Acetaminophen / Tylenol		Yes / No
☐ Ibuprofen / Advil, Motrin		Yes / No
☐ Naproxen/ Aleve, Naprosyn		Yes / No
☐ Nabumetone / Relafen		Yes / No
☐ Diclofenac (oral) / Arthrotec		Yes / No
☐ Etodolac / Lodine		Yes / No
☐ Ketorolac / Toradol		Yes / No
☐ Meloxicam / Mobic		Yes / No
☐ Celecoxib / Celebrex		Yes / No
☐ Cyclobenzaprine / Flexeril, Amrix		Yes / No
☐ Baclofen		Yes / No
☐ Methocarbamol / Robaxin		Yes / No
☐ Tizanidine / Zanaflex		Yes / No

☐ Metaxalone / Skelaxin		Yes / No
☐ Orphenadrine / Norflex		Yes / No
☐ Gabapentin / Neurontin, Horizant		Yes / No
☐ Pregabalin / Lyrica		Yes / No
☐ Milnacipran / Savella		Yes / No
☐ Duloxetine / Cymbalta		Yes / No
☐ Excedrin Migraine		Yes / No
☐ Butalbital / Fioricet, Fiorinal		Yes / No
☐ Sumatriptan / Imitrex		Yes / No
☐ Eletriptan / Relpax		Yes / No
☐ Rizatriptan / Maxalt		Yes / No
☐ Zolmitriptan / Zomig		Yes / No
☐ Topiramate / Topamax		Yes / No
☐ Amitriptyline / Elavil		Yes / No
☐ Propranolol		Yes / No
☐ Aimovig		Yes / No
☐ Nurtek		Yes / No
☐ Ubrelvy		Yes / No
☐ Qulipta		Yes / No
☐ Capsaicin cream		Yes / No
☐ Diclofenac (topical) / Flector patch, Voltaren gel		Yes / No
☐ Lidocaine / Lidoderm, ZT Lido, Salonpas patches		Yes / No
☐ Methyl Salicylate or Menthol / Bengay, IcyHot creams		Yes / No
☐ Compounded Pain Cream		Yes / No

Medical History:

❑ Alcoholism ❑ Arthritis ❑ Fibromyalgia ❑HIV-AIDS ❑ Kidney insuff. ❑ Kidney Failure (Hemodialysis)

❑ Sleep Apnea ❑ Osteoporosis ❑ Diabetes ❑ Neuropathy ❑ Thyroid problems ❑ COPD/ Asthma

❑ Chronic Headaches ❑ Migraines ❑ Stroke ❑ Multiple sclerosis ❑ RSD/ CRPS ❑ Heart Disease

❑ Heart attack ❑ Congestive Heart Failure ❑ Cardiac arrhythmia ❑ Pacemaker

Patient Name: _____ DOB: _____/_____/_____

Medical History (continued):

❑ Vascular Disease ❑ DVT-blood clots/ PE ❑ GI bleeding ❑Stomach ulcer ❑ Irritable Bowel Syndrome

❑ Heartburn - GERD ❑ Liver Cirrhosis ❑ Hepatitis B ❑ Hepatitis C ❑ Anxiety ❑Bipolar Disorder

❑ Schizophrenia ❑ Depression ❑Psychiatric Hosp.

❑ Cancer (what type)_____ Other:_____

Review of Systems: (Please place a checkmark by symptoms that you **CURRENTLY HAVE**):

System:	Symptom:	Place checkmark if present
General/Constitutional	Change in appetite Chills Fatigue Weight Loss	_____ _____ _____ _____
Respiratory	Cough Shortness of Breath Wheezing	_____ _____ _____
Cardiovascular	Chest Pain Irregular Heartbeat Palpitations	_____ _____ _____
Gastrointestinal	Change in Bowel Habits Constipation	_____ _____
Musculoskeletal	Arthritis/Arthralgia Joint Stiffness Muscle Aches Painful Joints Swollen Joints Weakness	_____ _____ _____ _____ _____ _____
Skin	Hives Itching Rash	_____ _____ _____
Neurological	Dizziness Headache Numbness/Tingling	_____ _____ _____
Psychological	Anxiety Auditory/Visual Hallucinations Depressed Mood Difficulty Sleeping Suicidal Thoughts	_____ _____ _____ _____ _____

Patient Name: _____ DOB: _____/_____/_____

Please list any **SURGERIES**, side**, surgeon's name and ~ date**: (i.e. Rt total knee replacement, Dr. Smith, 07/2009)

_____

_____

_____

_____

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Who do you live with? ☐ Alone ☐ Spouse ☐ Children ☐ Parents ☐ Friends ☐ Other: _____

Tobacco use: ☐ Current smoker ☐ Former smoker ☐ Non-smoker ☐ E-Cigarettes/ Vaping

If you are a current smoker of cigarettes: How often? _____

Are you interested in quitting? ☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit

If you are a former smoker, when did you quit? _____

Drug Use: Have you ever used illicit / illegal narcotics? ☐ Yes ☐ No

If yes, check which type: ☐ Heroin ☐ Cocaine ☐ PCP ☐ Marijuana ☐ Ecstasy ☐ LSD

☐ Crack ☐ Methamphetamine ☐ Other: _____

Are you still using it? ☐ Yes ☐ No If yes, date of last use _____

Have you previously been in drug treatment / rehab? ☐ Yes ☐ No If yes, when, where, and what type?

_____

Alcohol Use: How often? ☐ Don't drink ☐ 2-4 times per month ☐ 2-3 times per week

☐ > 4 times per week

If yes, how many drinks in a typical day? _____

Are you currently enrolled in an alcohol addiction treatment or rehab? ☐ Yes ☐ No

If yes, where and what type?_____

Patient Name: _____ DOB: _____/_____/_____

FAMILY HISTORY :

(Please check if you have any family members (parents, siblings, children, grandparents) who have the following diseases or conditions. Please indicate who has each condition:

☐ Mental illness such as depression, anxiety, bipolar disorder: _____

☐ History of drug addiction: _____

☐ History of alcohol addiction: _____

☐ Diabetes: _____

☐ Hypertension (high blood pressure): _____

☐ Stroke: _____

☐ Cancer: _____

☐ Other: _____

Opioid Risk Tool

Date: _____ Patient Name: _____

DOB: ____ / ____ / ____

		Mark each box that applies	Score if female	Score if male
Family history of substance abuse (mother / father)	Alcohol Illegal drugs Prescription drugs	☐ ☐ ☐	1 2 4	3 3 4
Personal history of substance abuse	Alcohol Illegal drugs Prescription drugs	☐ ☐ ☐	3 4 5	3 4 5
Age	If you are between the ages of 16 and 45 please mark the box.	☐	1	1
History of preadolescent sexual abuse committed against you.		☐	3	0
Psychological disease	Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia Depression	☐ ☐ ☐ ☐ ☐	2 2 2 2 1	2 2 2 2 1

Total: _____

PHQ-9

Date: _____ Patient Name: _____ DOB: ____ / ____ /____

During the past two weeks , have you often been bothered by one of the following problems?	(0) Not at all	(1) Several Days	(2) More than half the days	(3) Nearly every day
Little interest or pleasure in doing things?				
Feeling down, depressed, irritable or hopeless				
Trouble falling asleep or sleeping too much?				
Feeling tired or having little energy?				
Poor appetite, weight loss, or overeating?				
Feeling bad about yourself - feeling you are a failure, or have let your family down?				
Trouble concentrating on things, like reading the newspaper or watching television?				
Moving or speaking slowly that other people have noticed? **Or the opposite** Being so fidgety or restless that you were moving around a lot more than usual?				
Thoughts that you would be better off dead, or of hurting yourself in some way?				

Total: _____

If you are experiencing any of the problems listed on this form, how difficult have these problems made it for you to do work, take care of things at home, or get along with other people?

❏ Not difficult at all ❏ Somewhat difficult ❏ Very difficult ❏ Extremely difficult

Date: _____ Patient Name: _____ DOB: ____ / ____ /____

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Sleep Apnea Questionnaire

Date: _____ Patient Name: _____ DOB: ____ / ____ /____

☐ Male ☐ Female Age: _____ Height: _____ Weight: _____

STOP		
Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel TIRED, fatigued, or sleepy during the daytime?	Yes	No
Has anyone ever OBSERVED you stop breathing during your sle ep?	Yes	No
	Yes	No
BANG		
BMI more than 35kg/m2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

For Clinical Use Only – DO NOT WRITE BELOW THIS LINE

TOTAL SCORE		

High risk of OSA: Yes 5-8

Intermediate risk of OSA: Yes 3-4

Low risk of OSA: Yes 0-2

PATIENT NAME: _____

DOB: _____

Pain Frequency: ONLY CIRCLE ONE

CONSTANT, ON AND OFF, ALL DAY LONG, MOSTLY WITH POSITIONAL CHANGE, UNRELENTING

Pain Description: CIRCLE ALL THE APPLY

MILD, MODERATE, SEVERE, SHARP, THROBBING, DULL, ACHING, BURNING, PAIN IN ONE AREA OF THE BACK (FOCAL), RADIATING/SHOOTING DOWN THE LEG(S)

Pain Exacerbation: CIRCLE ALL THAT APPLY

BENDING OR STOOPING, LEANING BACKWARDS, LEANING FORWARDS WHILE WASHING DISHES, PICKING UP HEAVY OBJECTS, LIFTING SMALL LOADS, CARRYING AN AVERAGE SIZE SUITCASE, POSTERIOR EXTENSION AND LATERAL ROTATION

Pain Alleviation: CIRCLE ALL THAT APPLY

SITTING DOWN, RESTING, LAYING ON THE BACK, STOPPING ALL ACTIVITIES

Pain Location: CIRCLE ALL THAT APPLY

NECK, LOWER BACK, MID BACK, RIGHT SHOULDER, LEFT SHOULDER, BILATERAL SHOULDERS, RIGHT HIP, LEFT HIP, BILATERAL HIPS, RIGHT KNEE, LEFT KNEE, BILATERAL KNEES, RIGHT ANKLE/FOOT, LEFT ANKLE/FOOT, BILATERAL ANKLE/FEET.

Pregnancy Status

Date: _____ Patient Name: _____ DOB: ____ / ____ / ____

☐ N/A - Male

☐ Female, please continue below

1. Are you currently pregnant? ☐Yes ☐ No

2. Do you still experience a regular or irregular menstrual period? ☐Yes ☐ No

a. If YES, date of last menstrual period? _____ b. If NO,

- Age of menopause? _____
- Date of last menstrual period? _____

3. Do you still have reproductive organs? ☐Yes ☐ No

a. If YES, please select form of birth control:

- Condoms
- Diaphragm
- Spermicide
- Vaginal Ring
- Patch
- Oral Birth Control - Type: _____
- Depo - Date Administered: _____
- IUD - Type: _____ Date Administered: _____
- Implant - Type: _____ Date Administered: _____ ·
- Other - Type: _____ Date Administered: _____

b. If NO,

- NO - I have had a complete hysterectomy (uterus and both ovaries surgically removed)
  Date of complete hysterectomy? _____

- NO - I have had a partial hysterectomy (one or both ovaries remaining)
  Date of partial hysterectomy? _____

Patient Name: _____ DOB: ____ / ____ / ____

Pregnancy Status

Risks of Opioid Use in Pregnancy

There are significant risks associated with opioid use during pregnancy. Studies have shown treatments with opioid analgesics during pregnancy are linked to the following health risks:

- Known risks to the fetus:
    - Spina Bifida (a type of neural tube defect)
    - Hydrocephaly (buildup of fluid in the brain)
    - Glaucoma (an eye defect)
    - Gastroschisis (a defect of the abdominal wall)
    - Congenital Heart Defects
        - Conoventricular Septal Defect
        - Hypoplastic Left Heart Syndrome
        - Atrial Septal Defect
        - Tetralogy of Fallot
        - Pulmonary Valve Stenosis
    - Incomplete Pulmonary System Development
    - Neonatal Abstinence Syndrome
    - Low Birth Weight
- Known risks to the woman:
    - Miscarriage
    - Preterm Labor and/or Delivery
    - Categorization of High Risk Pregnancy

Please Read and Initial the Statements Below:

_____ I have read and understand the risks associated with the use of opioids during pregnancy as listed above.

_____ I understand that while being prescribed opioid medication, it is my responsibility to ensure that I am taking reasonable measures to prevent pregnancy.

_____ I agree to notify my provider with any changes in my method of birth control.

_____ I will immediately notify my provider should I become pregnant while receiving treatment.

_____ I will notify my provider should I plan to become pregnant.

Patient Signature: _____ Date: _____

Provider Signature: _____

Controlled Substance Agreement

Patient Name: _____ DOB: ____ / ____ / ____

Omega Pain Management understands that your pain can have an impact on your quality of life. To help reach your goals, we may recommend medications, diagnostic or therapeutic nerve blocks, physical and occupational therapy, and therapeutic massage, as appropriate and indicated. Narcotic medication for pain **MAY NOT** be prescribed on your first visit. This type of medication is prescribed solely based on the medical findings and treatment plan of an Omega Pain Management provider and not necessarily based on providers you may have visited previously. There are many possible side effects and safety concerns to consider prior to prescribing these types of medications. If we decide to use these medicines, the following conditions must be met:

*****Please read each statement below and initial in the spaces provided, acknowledging that you understand each item**** *

_____ I understand that using narcotics can be habit forming and acknowledge that such medications have certain risks or side effects including but not limited to physical dependence, addiction, tolerance to pain relief, sleepiness, constipation, nausea, vomiting, dry mouth, difficulty with urination, urinary retention, confusion, altered hormone levels, altered sexual dysfunction, itching, allergic reaction, slow breathing, or even death.

_____ I will not operate heavy equipment or drive while taking my medications until the side effects are known. I am aware my reflexes and reaction time may be slowed, even if I do not realize this. I am responsible for exhibiting good judgment in my daily affairs, including my use of controlled medications.

_____ I agree to take the prescribed medication exactly as I am told. I am not allowed to change dosage amounts or change the time schedule for taking medication without talking to my doctor first and gaining approval. You must come in for an appointment to discuss changes before they are made. If you self-adjust your medication regimen, it may not be continued.

_____ I acknowledge that the use of **ANY** illegal substance may result in immediate discharge from Omega Pain Management..

_____ I agree not to seek any narcotic pain medication from any other physician or provider while being treated by Omega Pain Management.

_____ I will tell my provider about any other medications and treatments I am receiving.

_____ I understand I am responsible for my medication and that **lost, stolen, or misplaced medication / prescriptions will not be replaced for any reason.**

_____ I agree that at any time my provider can call me in for a random pill count or drug screen and that I will be expected to arrive at the clinic within 2 hours of notification. It is my responsibility to provide and maintain a working telephone number where I can be contacted during regular business hours. If I am unable to answer personally, I am responsible for having a voice mail or other method of receiving the telephoned message that day. If you fail to come in for a drug screen or pill count on the day you are called, you may be discharged from the clinic.

_____ I am required to inform Omega Pain Management of out-of-town travel, prior to my departure. I understand I will be expected to call the office and inform a staff person of my name and the dates of travel. If I am called for a random pill count or drug screen and fail to show saying I was out of town, but do NOT have the trip noted in my chart, my provider reserves the right to discontinue my medication.

_____ All current medications prescribed by Omega Pain Management must be brought in its original packaging / bottle to every visit along with all remaining doses (pills, caps, patches, etc.).

Controlled Substance Agreement (continued)

_____ I understand I must not take any medication not prescribed to me or someone other than myself.

_____ I understand the use of alcohol and opioids together is potentially dangerous and have been advised against this. My practitioner may elect to discontinue opioids based on alcohol use.

_____ I understand that I may be subject to random drug screens.

_____ I understand I must not take medication left over from old prescriptions.

_____ Do not share medications with others. Do not sell medications.

_____ Do not take the medications in any manner other than prescribed. For example, do not chew or inject your medications.

_____ Keep all medication out of the reach of children. Do not leave your prescriptions lying around and unprotected for others to steal and/or abuse. Consider medication storage in a safe or lock box.

_____ Prescription refills will not be given prior to the planned refill date determined by the dose and quantity prescribed.

_____ For females of childbearing age: I understand that if I get pregnant, I should not use these medications because they could harm my baby. I am not pregnant now and I will alert my provider immediately if I become pregnant. I am aware I must have a contraceptive plan in place and use this consistently.

_____ Your medications may be discontinued or adjusted at your provider's discretion.

_____ I will use only one pharmacy (listed below) to fill my prescriptions and will notify my provider if a new pharmacy agreement needs to be updated.

Pharmacy: _____ Pharmacy Phone #: _____

_____ By signing this agreement, you give us permission to share your narcotic prescription history with other pharmacies, physician offices, or law enforcement agencies.

Patient's Name (print): _____ Date: _____

Patient Signature: _____

Provider Signature: _____

Informed Consent

Patient Name: _____ DOB: ____ / ____ / ____

Opioid is the medical name for a type of strong painkillers. Like all medications, opioids have potential to help people and / or cause harm. The purpose of this consent is to outline the overall benefits and potential harms so that together with your practitioner you can determine whether an opioid is suitable for you at this time. Not everyone will benefit from an opioid. In those who do, pain relief is generally modest. A 30% or greater reduction in pain is a meaningful effect. The possible side effects are the same for all the opioids, but different people react to each opioid individually. What might work well for you with few side effects may not work for the next person. Most side effects are worse when the medication is first started and can be effectively managed. Some side effects are more problematic with higher doses and longer-term use.

Using Controlled Medications to Treat Pain:

- Opioids are used to treat moderate-to-severe pain of any type.
- Opioids are best understood as potentially effective tools that can help reduce pain, improve function, and improve quality of life.
- Using these medications requires that both the provider and patient work together in a responsible way to ensure the best outcome, lowest side effects, and least complications.

How Do Opioids work?

- Opioid medications work at the injury site, the spinal cord, and the brain.
  - They dampen pain, but do not treat the underlying injury.
- They may help to prevent acute pain from becoming persistent chronic pain.
- These medications may work differently on different people because of many factors. · Side effects and complications will also individually vary.

What to Expect When You Take Controlled Medications for Pain and Related Conditions:

- Pain relief.
- Reduction of anxiety and stress caused by pain.
- Side effects.

What Should Not Be Expected from Treatment with Controlled Medications:

- Cure of the underlying injury.
- Total elimination of pain, anxiety, and stress.
- Loss of ability to feel other physical pain.

Opioid Side effects:

There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing).

_____ It is my responsibility to notify my physician/health care provider for any side effects that continue or are severe (i.e., sedation, confusion). I am also responsible for notifying my pain provider immediately if I need to visit another provider or need to visit an emergency room due to pain, or if I become pregnant.

Patient Name: _____ DOB: ____ / ____ / ____

Informed Consent

Opioid medications may cause a physical dependency marked by abstinence syndrome when they are stopped abruptly. If these medications are stopped or rapidly decreased the patient may experience chills, goosebumps, profuse sweating, increased pain, irritability, anxiety, agitation, and diarrhea. The medicines will not cause these symptoms if taken as prescribed and any decision to stop these medications should be done under the supervision of your physician in a slow downward taper.

Tolerance:

This means that over time the body becomes "use to" the medication and it feels less effective. The dose of the opioid may have to be adjusted to a dose that produces benefit and a realistic decrease of your pain yet does not have intolerable side effects. Sometimes this is not possible, and the opioid will have to be stopped and/or alternate therapy explored.

_____ I am aware that drowsiness or clouded thinking may make it dangerous for me to drive or operate heavy machinery. Alcohol or other medications that also cause drowsiness may worsen this effect.

_____ I agree not to drive or operate heavy machinery or sign legal documents while my practitioner is starting me on these new medications, significantly increasing my dose, or if I feel in any way impaired from this therapy at other times.

_____ I understand the use of alcohol and opioids together is potentially dangerous. I have been advised not to do this.

Misuse of medications:

Addiction: This is a psychological condition of use of a substance despite self- harm. Between six and ten percent of the population of the United States have problems with substance abuse and addiction. Controlled medications are likely to activate addictive behavior in this group of people. It is a disease that occurs in some individuals. Like becoming overweight does not necessarily mean you will become diabetic, taking opioids does not necessarily cause addiction, however, if you have risk factors for addiction (such as a strong family history of drug or alcohol abuse) or have had problems with drugs or alcohol in the past you must notify your practitioner since using opioids will put you at greater risk. The extent of this risk is not certain.

_____ I have notified my practitioner of any personal or family history of drug or alcohol abuse.

Diversion:

It is illegal to share your controlled medications with other people. It is illegal to provide false information to a prescriber in an attempt to obtain controlled medication. It is illegal to doctor shop or visit multiple doctors in an attempt to obtain controlled medications. Federal and state laws exist to address diversion problems. It is critical that you safeguard your controlled medications and use them only as prescribed by your provider.

Driving:

Studies of patients with chronic pain demonstrate improved driving skills when taking certain controlled medications. However, patients may have problems driving and need to realistically assess their own skills, as well as listen to others who drive with them to determine if they should be driving while taking these medications. You should consult the State Department of Transportation if you have questions about driving and taking your medication.

Common Sense Rules for Using Controlled Medications:

- Follow your provider's recommendations.
- Do not take more pills than prescribed without discussing this first with your provider and receiving permission to do so.
- Do not share medications with family or friends.
- Do not take medications from family or friends.

· Any medication you are prescribed may need to be tapered to stop. Please discuss with your provider before abruptly stopping any medications.

· Do not sell medications.

· Do not take medications in any manner other than prescribed. For example, do not chew, snort, or inject your medications.

· Keep all medications out of reach of children and pets.

· Do not leave your prescriptions lying around unprotected for others to steal and abuse them.

· Do not operate a motor vehicle if you feel mentally impaired using controlled medications. You are responsible for exhibiting good judgment in your daily affairs, including your use of controlled medications and operating motor vehicles or heavy equipment or tools.

Continued Use of Controlled Medication is based on your provider's judgment and a determination of whether the benefits to you of using controlled medications outweigh the risks of using them. Your provider may discontinue treating you at his or her discretion.

Your provider may require a consultation with an addiction specialist. Your provider may require more frequent visits.

We believe in treating your pain and we recognize the value of controlled medications in this process. When used properly, controlled medications can help restore comfort, function, and quality of life. However, as stated above, controlled medications may also have serious side effects and are highly controlled because of their potential for misuse and abuse. It is important to work with your provider and communicate openly and honestly with them about your pain. By doing so, medications can be used safely and successfully.

By your signature below, you are acknowledging that you have read and reviewed this agreement with your provider and that you have sufficient information to make a decision to use the controlled medications prescribed.

You should **NOT** sign this form if you do not believe you have enough information to make an informed decision about your use of controlled medications and how they fit into your pain management treatment plan.

Patient Name (printed) : _____ Date: _____

Patient Signature: _____

Provider Signature: _____

Consent to Treat

I hereby authorize and consent to the practice's physicians and their assistants and other practice professional staff providing outpatient medical treatment, supplies, services, equipment and other items related to my healthcare to me as determined to be necessary in their professional judgement. I have been informed of the nature and purpose of the treatment, and potential common side effects thereof, as well as alternative treatment modalities, the approximate estimated duration of my healthcare, and that I am able to withdraw my consent for treatment either orally or in writing whether prior to or during the anticipated treatment period.

_____ _____

Signature of Patient Date

_____

Printed Name of Patient

Authorization and Release

I authorize the release of any Protected Health Information including the diagnosis and the records of any treatment rendered to me during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to Omega Pain Management insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of services rendered on my behalf or my dependents.

_____ _____

Signature of Patient Date

_____

Printed Name of Patient

Patient Name: _____ DOB: _____/_____/_____

No Show / Cancellation / Late Arrival Policy

Omega Pain Management understands there are situations that arise that may prevent you from coming to your scheduled appointment. You need to make every effort to cancel within 24 hours. If you fail to cancel your appointment within 24 hours or no show/show up late for your scheduled appointment or procedure:

- You **WILL NOT** be given a priority appointment and will be scheduled at the next available appointment.
- If you show up late for your regular scheduled appointment, you will not be seen and will be rescheduled to the next available appointment.
- Medications will not be prescribed until the date of your next available appointment.
- Omega Pain Management is not obligated to work you in if you do not show up for your regularly scheduled appointment or procedure.
- Habitual no shows and late arrivals are grounds for dismissal from the practice.
- Follow up appointments are always scheduled at check out. It is your responsibility to keep track of the date and time of your appointments.
- You will be charged a cancellation fee of $35.00 for a regular missed appointment and $50.00 for a procedure. This fee is **NOT** covered by your insurance and **MUST** be paid prior to being seen again.

You must have an appointment. We are unable to accommodate walk-in visits.

We recommend you arrive 5-10 minutes early to your appointment.. To cancel or reschedule your appointment, please call the clinic directly and speak with the scheduler.

We understand that unavoidable and unforeseen circumstances may cause you to not be able to cancel within 24 hours. You should call immediately and advise us of the reason for the emergency. We ask that you provide documentation of emergencies, i.e. death of friend/family, hospitalization, illness, etc.

If you have any questions about this policy, please speak with your provider.

_____ _____

Patient Signature Date

Financial Responsibility

Patient Name: _____DOB: _____/_____/_____

Thank you for choosing our practice for your pain management needs. It is important that you understand the financial policies of this practice. It is just as important that you understand the terms of your medical coverage. Our staff is very knowledgeable of most insurance plans, but it is important that you understand the details of your personal plan. You will find your insurance company's phone number on the back of your insurance card and we encourage you to contact them with any questions you have pertaining to your coverage.

Patients with Medical Insurance:

· If you have an insurance plan that requires a referral, you must contact your PCP to obtain a referral PRIOR to receiving care from a specialty provider. Many insurers will not cover specialty services that are rendered without a referral and will leave you responsible for the costs. As a result, if we do not have a referral on file, we will not be able to render services to you.

· We participate with most major insurance plans and our billing office will submit claims for services rendered. It is the patient's responsibility to provide all necessary information needed to file the claims prior to leaving our office. We will file your primary and secondary insurance claims; however, your insurance company may need you to supply information directly. You may be financially responsible if you do not comply with this request.

· Please bring your insurance cards to each visit.

· Your insurance company **REQUIRES** us to collect co-payments at the time services are rendered. Failure to collect your co-payment is a contractual requirement so please be prepared to pay this on the date services are rendered. If you do not have your co-payment, we are not required to see you.

· Additionally, you may have deductible and/or coinsurance amounts that are your responsibility and required by your insurance carrier. These outstanding balances on your account following insurance processing will be billed to you.

· This practice will not waive or fail to collect any co-payments, co-insurance, deductibles, or any other financial responsibility in accordance with state and federal law as well as contractual agreements with payers. Full or partial financial responsibility may only be waived if a payment arrangement has been made.

· If the office is out of network, your insurance carrier may also pay you directly. As a patient, you are responsible for bringing in the payment and the Explanation of Benefits (EOB) from your insurance company.

Patient Balances:

· Any patient balances that remain delinquent after 90 days, with no response to requests or payment, may be referred to a collection agency. You will be responsible for any and all costs associated with the collection agency up to and including all legal costs.

· Our office accepts the following payment methods: Money Order, Cashier's Check, Cash, and Credit Card. **Self-pay payment methods**: Cashier's check, money order, and credit / debit card are the only accepted payment methods per state regulations.

· **Returned checks will be charged a $40 fee.**

Please read the Financial Policy carefully before signing.
I, the undersigned, understand the financial policies of Omega Pain Management and agree to abide by the plan I have signed. I also understand and agree to the following:

· To pay the amount owed to Omega Pain Management for professional treatment and services rendered

· I understand that I am financially responsible for any and all charges whether or not insurance covers them. If genuine financial difficulties exist, please call our office. We are happy to work with you in resolving your balance and may be able to set up payment arrangements. To speaking with our billing department please call (865) 337-5137 ext 231.

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Name of Patient/Responsible Party (Please Print) Relationship to Patient

Communicating with You – HIPAA

Patient Name: _____ DOB: ____ / ____ / ____

To effectively communicate with you about your medical information, we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message you left for your physician's office. **We may communicate with you through mail, secure email, and telephone, including leaving messages on your answering machine/voice mail.**

I authorize Omega Pain Management to **confirm my appointments** via:

☐ Cell Phone #: _____ ☐ Work Phone #: _____

☐ Home Phone #: _____ ☐ Any of the above

I authorize **information about my health** to be conveyed via:

☐ Cell Phone #: _____ ☐ Work Phone #: _____

☐ Home Phone #: _____ ☐ Any of the above

Omega Pain Management is authorized to discuss my medical information with the following individuals in accordance with HIPAA guidelines:

Name	Relationship	Phone Number
1.		
2.		
3.		
4.		

This request supersedes any prior request for communication of information I may have made.

Signature of Patient / Responsible Party: _____ Date:_____

Printed Name of Patient / Responsible Party: _____Date:_____

Omega Pain Management
6348 Lonas Spring Drive
Knoxville, TN 37909

HIPAA Omnibus Rule

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES
CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing, we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy & Information Practices for Omega Pain Management. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

_____ _____
Please print name of Patient Signature of Patient/Guardian of Patient

TRANSPORTATION SERVICES:
Do you use a transportation service? ☐ Yes ☐ No

If yes, do you authorize Omega Pain Management to give them information regarding dates/times of your appointments? ☐ Yes ☐ No

_____ _____
Signature of Patient or Guardian Date

Omega Pain Management Notice of Privacy Practices

Contact Phone # (865) 337-5137

This notice contains important information about our privacy practices which were revised pursuant to the Health Insurance Portability and Accountability Act of 1996 and related regulations. This notice describes how your Protected Health Information may be used and disclosed, and indicates how you get access to this information. Please review it carefully. If you have any questions about this notice, please contact our Privacy Officer: Lauren Yoes OUR COMMITMENT TO YOUR PRIVACY Summary

1. We are dedicated to maintaining the privacy of your medical information. In conducting our business, we will create records regarding the treatment and services we provide to you.
2. Your medical records are our property. However, we are required by law:
    - To maintain the confidentiality of your medical information;
    - To provide you with this notice of our legal duties and privacy practices concerning your medical information called Notice of Privacy Practices;
    - To follow the terms of our notice of privacy practices in effect at the time.
3. This notice provides you with the following important information:
    - How we may use and disclose your medical information;
    - Your privacy rights regarding your medical information;
    - Our obligations concerning the use and disclosure of your medical information. Changes to this Notice The terms of this notice apply to all records containing your medical information that are created or retained by us. We reserve the right to revise, change or amend our notice of privacy practices. Any revision or amendment to this notice will be effective for all of the information that we already have about you, as well as any medical information that we may receive, create, or maintain

in the future. You may request a copy of our most current notice during any visit to our practice.

How we may use and disclose your medical information

The following categories describe the different ways in which we may use and disclose your Protected Health Information. Please note that each particular use or disclosure is not necessarily listed below. However, the different ways we are permitted to use and disclose your medication information do fall within one of the listed categories. Treatment We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We may also disclose protected health information to their physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician. Payment We may use and disclose your medical information 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 and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for your

treatment. We also may use and disclose your medical information to obtain payment from other third parties who may be responsible for such costs. Also, we may use your medical information to bill you directly for services and items under applicable law. Health Care Operations We may use and disclose your medical information to operate our business. These uses and disclosures are important to ensure that you receive quality care and that our organization is well run. An example of the way in which we may use and disclose your information for our operations would be to evaluate the quality of care you received from us. We may also disclose your information to doctors, nurses and students for review and learning purposes. We maintain safeguards to protect your Protected Health Information against unauthorized access and uses. We may share your protected health information with third party “business associates” that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. Appointment Reminders Our organization may use and disclose your protected health information to remind you that you have any appointment. Disclosure We shall only disclose protected health information as permitted by law or with your permission. In addition, we shall make every effort to prevent unintentional disclosure although the regulations consider such disclosure legal. When necessary for your care or treatment, our operations and related activities, we use protected health information internally and may disclose such information to other healthcare providers (doctors,

dentists, hospitals, nursing homes or other covered healthcare providers, insurers, third party administrators, payers, and others who may be financially responsible for payment for services and benefits you receive, vendors, consultants, government authorities and other surveying entities and their respective agents). These parties are required to keep your protected health information confidential, as provided by law.

Some examples of what we do with the information we collect and the reasons:

1. Administration of health benefits policies or contracts which may involve claims payment and management; utilization review and Management; medical necessity review; coordination of care and benefits;
2. Quality assessment and improvement activities, such as peer review and credentialing of participating providers, program development and accreditation;
3. Performance measurement and outcomes assessment and health claims analysis;
4. Data and Information systems management; and
5. Performing regulatory compliance/reporting, and public health activities; responding to requests for information from regulatory authorities, responding to government agency or court subpoenas as required by law, reporting suspected or actual fraud or other criminal activity; conducting litigation, arbitration and performing third-party liability, subrogation and related activities. Others Involved in Your Healthcare Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in

disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care. Emergencies We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you. Communication Barriers We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances. Treatment Alternatives/Health-Related We may use and disclose your medical information to inform you of treatment alternatives and/or health-related benefits and services that may be of interest to you. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include: Required by law We will use or disclose medical information about you when required by applicable law.

Public Health Activities Our organization may disclose your medical information for public health activities, including;

1. To prevent or control disease, injury or disability;
2. To maintain vital records, such as births and deaths;
3. To report child abuse or neglect;
4. To notify a person regarding potential exposure to a communicable disease;

5. To notify a person regarding a potential risk for spreading or contracting a disease or condition;
6. To report reactions to drugs or problems with products or devices;
7. To contact public health surveillance, investigation or intervention;
8. To notify individuals if a product or device they may be using has been recalled;
9. To notify appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient including domestic violence; however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information; and
10. To notify your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance. Abuse, Neglect and Domestic Violence We may disclose your medical information to a government authority if we believe you are a victim of abuse, neglect or domestic violence. If we make such a disclosure, we will inform you of it, unless we think informing you places you at risk of serious harm or if we were to inform your personal representative, is otherwise not in your best interest. Communicable Diseases We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition. Health Oversight Activities We may disclose your medical information to a health oversight agency for activities authorized by law. Oversight activities can include, for example, 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 and compliance with civil rights laws. Lawsuits and Similar Proceedings We may use and disclose your medical information in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your medical information in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement We may release medical information if asked to do so by law enforcement officials:

1. Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement per state law;
2. Concerning a death we believe might have resulted from criminal conduct;
3. Regarding criminal conduct at our practice.
4. In response to a warrant, summons, court order, subpoena or similar legal process;
5. To identify/locate a suspect, material witness, fugitive or missing person; and
6. In an emergency, to report a crime (including the locating or victim(s) of the crime, or the description, identity or location of the perpetrator). Coroners, Medical Examiners, and Funeral Directors We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We may also release medical information about our patients to funeral directors as necessary to carry out their duties. Organ and Tissue Donation We may use or disclose your medical information to organizations that handle organ and tissue procurement, banking or transplantation. Serious Threats to Health or Safety We may use or disclose your medical information when necessary to reduce or prevent a serious threat to your health and safety or another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. Specialized Government Functions We may disclose your medical information if you are a member of the U. S. or foreign military forces (including veterans) and if required by the appropriate military command authorities. In addition, we may disclose your medical information to federal and/or state and/or local officials for intelligence and national security activities authorized by law. We also may disclose your medical information to federal officials in order to protect the President, other officials or foreign heads of state or to conduct investigations. Furthermore, we may disclose your medical information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

Disclosure for these purposes would be necessary:

1. For the institution to provide health care services to you;
2. For safety and security of the institution; and
3. To protect your health and safety or the health and safety of other individuals. Workers' Compensation or Disability Claims We may release your medical information for your workers' compensation and disability claims and similar program to appropriate agencies.

Your rights regarding your medical information

You have the following rights regarding the medical information that we maintain about you: Requesting Restrictions When requested in writing, you have the right to request a restriction in your medical information for treatment, payment or healthcare operations. Additionally, you have the right to request that we limit our disclosure of your medical information to individuals involved in your care or the payment for your care, such as family members and friends. 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 and disclosure of your medical information you must make your request in writing to the Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. We will accommodate reasonable requests. You need not give a reason for your request. Confidential Communications You have the right to request that we communicate with you about your health and related issues in a particular manner, or at a certain location. For instance, you may ask that we contact you by mail, rather than by telephone, or at home rather than work. In order to request a type of confidential communication, you must make a written request to the Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. We will

accommodate reasonable requests. You do not need to give a reason for your request. Inspection and Copies You have the right to inspect and obtain a copy of the medical information that may be used to make decisions about you, including patient medical records and billing records. Please make all record requests through the secure messaging service on our website. Otherwise, you must submit your request in writing to the Privacy Officer in order to inspect/or obtain a copy of your medical information. In accordance with state law we may charge a fee. In accordance with law and our best judgment, we may deny your request to inspect and/or copy your medical information in certain limited circumstances; however, you may request a review of our denial. Amendment You may ask to amend your medical information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by our Practice. To request an amendment, your request must be made in writing to our Practice. You must provide us with a reason that supports your request for amendment. We may deny your request if you fail to submit your request and the reason supporting your request in writing.
Also, we may deny your request if the amendment would violate any law or statute or if you ask us to amend information that is:

1. Accurate and complete;
2. Was not created by us; or
3. If the individual who created the information is no longer an employee of our Practice.

Accounting of Disclosures An accounting of disclosures is a list of certain disclosures we have made of your medical information that you did not specifically authorize. You have the right to request a copy of our accounting of disclosures for your medical information. Your request must be made in writing to the Privacy Officer. All requests for an accounting of disclosures must state a time period that may be no longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period is

free of charge. A charge for subsequent requests in the same 12-month period will be imposed in accordance with state law. Right to a Paper Copy of This Notice You have the right to receive a paper copy of our Notice of Privacy Practices. You may print a copy of this notice from our website. To obtain a copy of this notice, ask any member of our staff or contact the Privacy Officer. Right to File a Complaint You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint. Right to Provide an Authorization for other Used and Disclosures We shall make a good faith effort to obtain your written authorization for uses and disclosures that are not identified by this notice or are not permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your medical information may be revoked at any time in writing by sending a written, signed and dated request to the Privacy Officer. After you revoke your authorization, we will no longer use or disclose your medical information for the reasons described in the authorization. Of course, we are unable to take back any disclosures that we have already made with your permission. Please note that we are required to retain records of your care.

Effective Date 12/1/2014