PRECISION
PAIN MANAGEMENT

Thank you in advance for taking the time to complete our paperwork. We are aware that it is extensive and time consuming. We hope you understand that this is our first introduction to you and your medical history and the best way for us to begin to understand your pain. Below is a checklist to help guide you through this process. We welcome you to the Precision Pain Management family and we look forward to helping you find relief from your pain and getting you back to your normal daily activities.

Please complete the following forms:

- Personal/ Contact Information
- Insurance Information
- Healthcare Authorization
- Controlled Substance Agreement
- Medical & Pain History
- Out of network form
- Behavioral Health Screening Questionnaire
- HIPAA Form
- Office Medication Agreement

➢ Scheduled Appointments

If you are more than 15 minutes past your scheduled appointment you may be rescheduled. Patients are responsible for bringing in or getting a referral if needed through their insurance company. If at the time of your scheduled appointment no referral is received you will be rescheduled to a later date.

➢ Account Balances

Account balances must be up to date when booking a follow up appointment. Patients who have any questions regarding bills or payment options may call our medical biller for clarification.

_____	_____	_____
Print Name	**Signature Patient/ Guardian**	**Date**

PRECISION
PAIN MANAGEMENT

First Name	Middle Initial	Last Name
Current Address	City, State, Zip Code	

Date of Birth	Age	Sex Male Female	Marital Status Single Married Divorced Widowed
Preferred Language	Race		Ethnicity
Home Phone	Work Phone		Cell Phone
E-mail Address	Social Security Number (For insurance and record keeping only)		
Employer	Occupation		
Guarantor Full Name/ Person Responsible for Payment	Relation to Patient Self Spouse Legal Guardian		
Medical Insurance Company Name	Medical Insurance ID Number		
Policy Holder/ Insured's Full Name	Patient's Relation to Insured Self Spouse Legal Guardian		
Policy Holder/Insured's Date of Birth	Insured's Employer Name		
Emergency Contact	Contact Number		

The undersigned hereby authorizes PRECISION PAIN MANAGEMENT, LLC to release or obtain information as may be necessary to determine benefits entitlements, process payment of claim and/or diagnostic and therapeutic information for healthcare services provided to the above-named patient. I authorize payment of medical benefits to PRECISION PAIN MANAGEMENT, LLC for medical services. Should my insurance(s) deny or if PRECISION PAIN MANAGEMENT, LLC does not participate with my insurance, I am aware I am responsible for the payment. Also, or obligations of my insurance (such as referrals written to PRECISION PAIN MANAGEMENT, LLC, referral dates and visits, properly determining primary versus secondary insurance, etc.) are my responsibility. Should PRECISION PAIN MANAGEMENT, LLC submit to my nonparticipating insurance as a courtesy I realized I may be responsible for payment. If this is a workers comp claim and the workers comp insurance fails to make payment after one year I will be

contact my pharmacy, to release or obtain information as well as speak to my family members and/or emergency contacts, leave messages pertaining to my medical condition and/or appointment on an answering machine if applicable. I authorize PRECISION PAIN MANAGEMENT, LLC to download insurance eligibility and medication history. I authorize a copy of this authorization to be used in the place of an original. I also understand I have the right to revoke this authorization except to the extent the action has a ready been taken in reliance of the authorization. This authorization will be in effect until seven years after the last date of treatment or until it is revoked by either party. Once the information is disclosed to a third-party, they may intern disclose it to someone else and they may not be a covered entity under the Health Insurance Portability and Accountability Act. I may be held responsible for collection costs, attorney fees, and court costs for delinquent accounts. I understand that the aforementioned omce is not responsible for loss of, damage to or theft of my personal possessions while I am on the premises. Regarding Medicare patients: I request that payment of authorized Medicare and/or MediGap benefits be made either to me on my behalf or to PRECISION PAIN MANAGEMENT, LLC for any services furnished me by the physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents and/or the Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature (if signed by patient representative, state relationship) Date

PRECISION PAIN MANAGEMENT

INSURANCE INFORMATION FORM

Name_____ Date of Birth_____ Date_____

WORKERS COMP OR MVA RELATED? Please complete this section.

Is this a job-related injury? NO YES if yes, please advise the front desk staff.

Is this the car accident related injury? NO YES if yes, please also complete health insurance info.

Is car insurance primary to health insurance? NO YES if yes, please also complete health insurance info.

Insurance Company Name_____ Adjuster_____

Claim #_____ Date of Injury_____/_____/_____

Insurance *Billing*Address_____ Phone_____

Street and/or PO Box

_____ Fax_____

City State ZIP Code

Employer's Name_____

Employer's Address_____ Phone_____

Street and/or PO Box

_____ Contact Person_____

City State ZIP Code

Attorney's Name_____ Phone_____

Attorney's Address_____ Fax_____

Street and/PO Box

_____ Contact Person_____

City State ZIP Code

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARDS AND DRIVERS LICENSE TO BE COPIED

Primary Insurance Plan Name_____

Insured: SELF SPOUSE PARENT OTHER If other than self, please complete the following:

Subscriber's Name_____ Date of Birth_____

Subscriber's Address_____ Subscriber's Gender: MALE FEMALE

Street Apartment

_____ _____

City State ZIP Code Subscribers Social Security number

Secondary Insurance Plan Name_____

Insured: SELF SPOUSE PARENT OTHER if other than self, please complete the following:

Subscriber's Name_____ Date of Birth_____

Subscriber's Address_____ Subscriber's Gender MALE FEMALE

Street Apartment

_____ _____

City State ZIP Code Subscribers Social Security number

I declare, under penalty of perjury, that the above is true and accurate. I authorize a copy of this form and my signature to be used in lieu of an original. Should I fail to provide my insurance in their proper order I will be responsible for payment to two penalties of timely filing.

_____ _____

Patient Signature(if signed by patient representative, state relationship) Date

PRECISION
PAIN MANAGEMENT

Dear Patient,

Please be advised Precision Pain Management is *Out of Network* with your insurance company. We'll be submitting a claim directly to your insurance carrier for you. However, because our facility is *Out of Network*, your insurance company may make the payment directly to you.

DO NOT CASH THE INSURANCE CHECK.

Instead, please address the back of the check and write "Payable to Precision Pain Management" below your signature. You must then send the insurance check to Precision Pain Management, 300 W. Water Street, Suite A, Toms River, NJ 08753 as soon as you receive it. The check must be sent within 10 days of receipt otherwise your account will be put into collection for an outstanding balance. Unfortunately, we will not be able to provide further services until the balance is satisfied.

FORWARD A COPY OF THE EXPLANATION OF BENEFITS WITH THE INSURANCE CHECK.

Along with the payment will be an Explanation of Benefits (EOB) statement. The EOB explains how your carrier arrived at the amount of money they issued. Failure to provide this copy to us may impact the balance we consider to be your remaining obligation.

Thank you for your understanding and cooperation.

Sincerely,

Precision Pain Management, LLC

_____ _____

Patient or Authorized Representative Signature Date

PRECISION
PAIN MANAGEMENT

History & Physical

Patient Name:_____ **Date:**_____

Date of Birth:_____ **SEX:**_____ **Age:**_____ **Height:**_____ **Weight:**_____

Last Known Blood pressure:_____

Are you right or left-handed? Right Left (Please circle one)

Are you taking aspirin or any other blood thinner? Y N (Please circle one)

Name of blood thinner (if yes)_____

Referral: Patient comes referred by_____

Primary Care Physician's Name_____

Worker's Compensation Case? Y N (Please circle one)

Auto Accident? Y N (Please circle one)

Represented by Attorney? Y N (Please circle one)

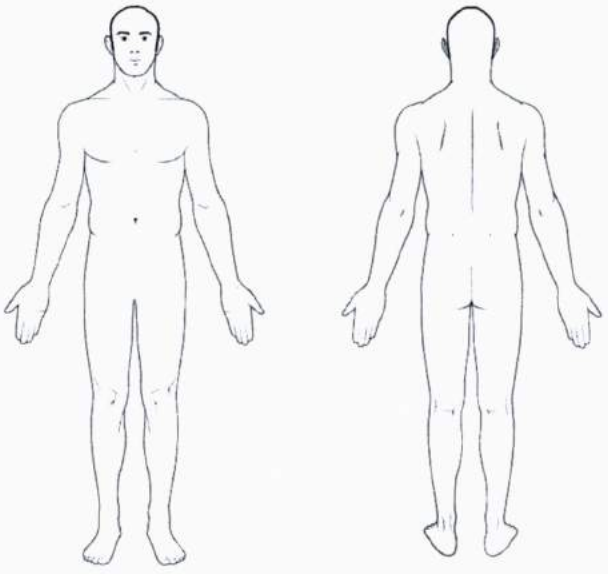
Attorney Name:_____ **Phone:**_____

Lawsuit Pending? Y N (Please circle one)

PRECISION
PAIN MANAGEMENT

Pain Body Chart

On the diagram below **"Shade"** all areas where you feel pain and **"X"** the areas that hurt the most



Below please circle which side/sides hurt on the areas of pain in which you state are painful

1) Head/headaches:	**L**	**R**	**Both**	**8) Arm:**	**L**	**R**	**Both**	**15) Leg:**	**L**	**R**	**Both**
2) Facial:	**L**	**R**	**Both**	**9) Elbow:**	**L**	**R**	**Both**	**16) Knee:**	**L**	**R**	**Both**
3) Jaw:	**L**	**R**	**Both**	**10) Wrist:**	**L**	**R**	**Both**	**17) Ankle:**	**L**	**R**	**Both**
4) Neck:	**L**	**R**	**Both**	**11) Finger:**	**L**	**R**	**Both**	**18) Foot:**	**L**	**R**	**Both**
5) Shoulder:	**L**	**R**	**Both**	**12) Mid Back:**	**L**	**R**	**Both**	**19) Toe:**	**L**	**R**	**Both**
6) Chest:	**L**	**R**	**Both**	**13) Low Back:**	**L**	**R**	**Both**				
7) Stomach:	**L**	**R**	**Both**	**14) Hip:**	**L**	**R**	**Both**				

Event associated with the onset of pain

Car Accident_____ Lifting_____ Fall_____ Work Related_____ Unknown_____

Other_____

When did the first sign/symptom occur? **Year:**_____ **Month:**_____

<u>Quality of Pain:</u> **Use one box for top 3 body sites where you experience pain** <u>**Today.**</u>

(Example: one box for back, one for leg, and another for neck)

Circle the word that <u>best</u> describes the pain at the site. Also indicate the intensity of the pain.

Body Site: ____________________ **Circle the word that best describes the pain**

Sharp Numb Burning Intermittent Exhausting Shooting Throbbing Cramping Continuous Miserable Stabbing Aching Tingling Electric Stinging During Sleep Constant

0-10 NUMERIC PAIN RATING SCALE

0 1 2 3 4 5 6 7 8 9 10

NONE MILD MODERATE SEVERE

Body Site: ____________________ **Circle the word that best describes the pain**

Sharp Numb Burning Intermittent Exhausting Shooting Throbbing Cramping Continuous Miserable Stabbing Aching Tingling Electric Stinging During Sleep Constant

0-10 NUMERIC PAIN RATING SCALE

0 1 2 3 4 5 6 7 8 9 10

NONE MILD MODERATE SEVERE

Body Site: ____________________ **Circle the word that best describes the pain**

Sharp Numb Burning Intermittent Exhausting Shooting Throbbing Cramping Continuous Miserable Stabbing Aching Tingling Electric Stinging During Sleep Constant

0-10 NUMERIC PAIN RATING SCALE

0 1 2 3 4 5 6 7 8 9 10

NONE MILD MODERATE SEVERE

Modifying Factors: Circle the number below that best describes the amount of pain relief that treatment is providing or has provided in the past.

	Never Tried	No relief (0)	Complete Relief (10)	Receiving now
Physical Therapy	☐	0 1 2 3 4 5 6 7 8 9 10		☐
Surgery	☐	0 1 2 3 4 5 6 7 8 9 10		☐
Injection/Nerve Block	☐	0 1 2 3 4 5 6 7 8 9 10		☐
Drug/medication therapy	☐	0 1 2 3 4 5 6 7 8 9 10		☐
Chiropractor	☐	0 1 2 3 4 5 6 7 8 9 10		☐
TENS	☐	0 1 2 3 4 5 6 7 8 9 10		☐
Acupuncture	☐	0 1 2 3 4 5 6 7 8 9 10		☐

Does any of the following make your pain worse? (Please circle which applies)

- **Coughing or sneezing?** Y N
- **Sitting** Y N If yes, after how many minutes?_____
- **Standing** Y N If yes, after how many minutes?_____
- **Walking** Y N If yes, after how many minutes?_____
- **Physical Activity** Y N If yes, what type?_____
- **Driving** Y N
- **Stress** Y N
- **Work** Y N
- **Daily Activity** Y N If yes, what type?_____
- **Other** Y N If yes, explain_____

Does any of the following make the pain better? (Please circle which applies)

- **Ice** Y N
- **Heat** Y N
- **Bengay** Y N
- **Brace/Bandage** Y N
- **Cane/Crutches** Y N
- **NSAID's** Y N
- **Physical Therapy** Y N
- **Tiger Balm** Y N
- **Tylenol** Y N

Do you have any of the following symptoms where your pain is?

- **Numbness or tingling ("pins and needles")** Y N
- **Bladder or bowel problems(Incontinence or leakage without your control)** Y N
- **Muscle spasms or cramps ("Charley Horses")** Y N

If yes, are these at night, during the day or both?_____

- **Muscle Weakness** Y N

Specific Studies Done: (Please Circle which applies)

MRI **X-ray** **CT/Myelogram** **Bone Scan** **EMG**

Date	Procedure	Facility where performed
1.		
2.		
3.		
4.		

Past Medical History: Please circle which applies to medical problems you have had in the past and current.

Cardiovascular Disease	Y	N
Heart Attack	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Chest Pain/ Angina	☐	☐
Arrhythmias or Palpitations	☐	☐
Heart Failure	☐	☐
Valvular Disease	☐	☐
Pacemaker	☐	☐
Shortness of breath	☐	☐
Angioplasty	☐	☐

Other:_____

Pulmonary Disease	Y	N
Asthma	☐	☐
Emphysema/COPD	☐	☐
Lung Surgery	☐	☐
Bronchitis	☐	☐
Sleep Apnea	☐	☐

Other:_____

Neurologic Disease	Y	N
Seizures/ Epilepsy	☐	☐
Stroke	☐	☐
Mini-Stroke/TIA	☐	☐
Alzheimer's	☐	☐
Parkinson's	☐	☐
Multiple sclerosis	☐	☐

Other:_____

Gastrointestinal Disease	Y	N
Acid Reflux/GERD	☐	☐
Hiatal Hernia	☐	☐
Gastric Ulcer	☐	☐
Diverticulitis	☐	☐

Other:_____

Cancer:	Y	N

Location:_____

Skin Disease	Y	N
Psoriasis	☐	☐

Other:_____

Kidney Disease	Y	N
Kidney Failure	☐	☐

Other:_____

Endocrine Disease	Y	N
Diabetes (High Blood Sugar)	☐	☐
Thyroid Problems	☐	☐

Other:_____

Musculoskeletal Disease	Y	N
Fibromyalgia/Chronic Fatigue Syndrome	☐	☐
Arthritis	☐	☐
Raynaud's Disease	☐	☐
Scoliosis	☐	☐
Lupus	☐	☐
Osteoporosis	☐	☐

Other_____

Psychiatric Disease	Y	N
Depression	☐	☐
Anxiety	☐	☐
Drug Addiction	☐	☐
Suicidal Ideas/Attempts	☐	☐
Child Abuse	☐	☐
Eating Disorders	☐	☐

Immunologic Disease	Y	N
HIV	☐	☐
Liver Disease	☐	☐
Hepatitis/Jaundice	☐	☐

Other:_____

Other Significant Medical Conditions/Diseases

_____

_____

_____

_____

Family History: Describe any relevant medical history in your family that relates to your chronic pain

_____

_____

_____

_____

Previous Surgeries: Year and surgery performed

_____

_____

_____

_____

Medications: Currently used

_____

_____

_____

_____

Herbs: Over the counter

_____

_____

Medications that you have tried in the past for your chronic pain and you no longer take:

Medication	Reason you are no longer taken it
_____	_____
_____	_____
_____	_____
_____	_____

Allergies: Allergic to latex? Y N

Allergic to Iodine or Shellfish? Y N

Allergic to IV Dye or Contrast Dye? Y N

Allergic to Medication? Y N

List ALL medications to which you are allergic to:_____

_____

Social History: ☐ Single ☐ Married ☐ Widowed ☐ Children: How many? _____

Domestic Situation: Do you live alone? Y N

Are there any substance abuse issues in the household? Y N

If yes, please explain: _____

Are you able to take care of yourself? Y N

If no, please enter name of care of caregiver? _____

Employment: Employed?

If yes, please describe job performed_____

Years worked? _____ Why did you leave? _____

Substance Abuse: Next to each drug or substance that you circle, indicate if you use or have used:

Never (N) Infrequently (I) Frequently (F) Regularly (R)

Which of the following drugs or substances, if any, have you used in the **past**? (circle all that apply)

Alcohol_____ Barbiturates_____ Cocaine_____ Heroin_____

Amphetamines_____ Marijuana_____

Are you **presently** using any of the following drugs or substances? (circle all that apply)

Alcohol_____ Barbiturates_____ Cocaine_____ Heroin_____

Amphetamines_____ Marijuana_____

Smoke: ☐ Yes ☐No Packs/Per day _____ Years _____ ☐ Quit when? _____

Are you or could you be pregnant? ☐Yes ☐ No ☐ Not applicable

_____ _____

Patient Signature Date

PRECISION
PAIN MANAGEMENT

300 WEST WATER STREET, TOMS RIVER NJ 08753

PHONE 732 800-2760 FAX 732 505-5432
www.DrCPPM.com
Email: DRC@DRCPPM.COM

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name:_____ Date of Birth:_____

Previous Name:_____ Social Security:_____

I request and authorize (Authorized Individual) to release healthcare information of the patient named above to:

Precision Pain Management
300 West Water Street – Suite A
Toms River, NJ 08753

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition or dates.

List here_____

☐ All healthcare information ☐ Other

List here_____

Additional information_____

☐ Yes ☐ No

I Authorize the release of any records regarding Pain Management treatment to the person(s) listed above.

Patient Signature_____ Date_____

PRECISION
PAIN MANAGEMENT

Information and Agreement Regarding Controlled Substances

This agreement is a tool to protect you and your physician by establishing guidelines, within the laws for the proper controlled substance use. The words "we" and "our" refer to the facility, and the words "I", "you", "your", "me", or "my" refer to you, the patient.

We are committed to doing all we can to treat your chronic pain condition. In some cases, controlled substances are used as a therapeutic option in the management of chronic pain and related anxiety and depression, which is strictly regulated by both state and federal agencies. The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

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

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

1. I understand that chronic opioid therapy has been associated with not only addiction and abuse, but also multiple medical problems including the suppression of endocrine function resulting in low hormonal levels in men and women which may affect mood, stamina, desire, and physical and sexual performance.

2. **For female patients:** If I plan to become pregnant or believe that I have become pregnant while taking these medications unless my obstetrician recommends otherwise; the baby will be physically dependent upon opioids. I will immediately call my obstetrician and this office to inform them of my pregnancy. I am also aware that opioids may cause birth defect, even though it is extremely rare.

3. I have been informed that long-term and/or high doses of pain medication may also cause increased levels of pain known as opioid hyperalgesia (pain medicine causing more pain) where simple touch will be perceived as pain and pain gradually increases in intensity and also the location with hurting all over my body. I understand that opioid- induced hyperalgesia is a normal, expected result of using these medications for a long period of time. This may be helped with the addition of non-steroidal anti-inflammatory drugs such as Advil, ibuprofen, ect., or by reducing or stopping opioids.

4. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine is markedly decreased, stopped, or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome.

5. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable, and could even result in a heart attack, stroke, or death.

6. I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. If it occurs, increasing doses may not always help and may cause acceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment, reduce the dose, or stop it. The best way to prevent or slow down the tolerance is to not take opioids every day or at most once, targeted to specific activities during the day. A twice a day schedule should be indicated only in a few selected patients during a limited amount of time. For long term treatment, the use of extended release medication is indicated.

7. I understand that I must tell the physician whose signature appears below or during his/her absence, the covering physician, all drugs that I am taking, have purchased, or have obtained, even over-the- counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death.

8. I will not seek prescriptions for controlled substances for chronic pain from any other physician, health care provider, or dentist. I understand it is unlawful to be prescribed the same type of controlled medication (opioids) by more than one physician at a time without each physician's knowledge. Prescriptions for pain from a surgical procedure that are given by the surgeon, are exceptions if all doctors are informed in advance and authorized. Your chronic pain doctor should not treat your acute post- operative pain.

9. I also understand that it is unlawful to obtain or to attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician or his/her staff knowingly withholding facts from a physician or his/her staff (including failure to inform physician or his/her staff of all controlled substances that I have been prescribed or illegal street drugs).

10. You are expected to inform our office of any new medications or medical conditions and of any adverse effects you experience from any of the medications that you take.

11. You may not share, sell, or otherwise permit others to have access to these medications.

12. These drugs should not be stopped abruptly, as abstinence or withdrawal syndrome will likely develop.

13. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any legal drugs except as specifically authorized but the

physician by the physician whose signature appears below or during his/ her absence by the covering physician, as set forth in Section 1 above. I will not use, purchase, or otherwise obtain any scheduled I drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance or any combination of substances (e.g., alcohol and prescribed drugs), may impair my driving ability and may result in DUI charges. I acknowledge that opioids may impair my ability to drive. I acknowledge that driving or operating machinery while impaired is my responsibility & that I have been advised to avoid.

14. **Unannounced urine serum toxicology screens may be requested and your cooperation is required.** Presence of unauthorized substances may prompt referral for assessment for addictive disorders and/or dismissal from the practice. I understand that the facility may call me for a pill count at any time. I will go the same day that I am called with the original vials and all remaining pills. I don't go the same day, I might not be eligible to continue receiving these medications.

15. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescriptions. They should not be left where other might see otherwise have access to them

16. Since the drugs may be hazardous and/or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out reach out people.

17. **Medications may not be replaced if they are lost, get wet, are destroyed, left on a plane, etc.** If the medication has been stolen, I understand that more medications will not be supplemented. It is my responsibility to keep my opioid medication safe.

18. Medication changes will not be made between appointments unless medically necessary, which will be determined by the physician. Early refills will not be given.

19. Unscheduled "drop in" visits for prescription refills are not allowed, as the physicians are busy seeing scheduled patients.

20. Prescriptions **cannot be mailed** to you.

21. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

22. It should be understood that any medical treatment is initially a trial and that continued prescription is contingent on evidence of benefit.

23. The risk and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation).

24. In the event you are arrested or incarcerated refills on controlled substances will not be given.

25. I also understand that the prescribing physician has permission to discuss all diagnostic and treatment details, including medications, with dispensing pharmacist, other professionals who provide your health care or appropriate drug and law enforcement agencies for the purpose of maintaining accountability.

26. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you are obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

27. I understand that failure to adhere to these policies may result in cessation of therapy of therapy with controlled substances prescribed by this physician and other physicians at the law enforcement officials may be contacted. I affirm that I have full right and power to sign and to be bound by this agreement, that I have read it, and understand and accept all of its terms. A copy of this document has been given to me. A copy of this document is uploaded to Drcppm.com for my review at any time.

28. Addendum to this agreement will be generated every time that a new medication is prescribed or dose change. This addendum will bind the patient to the prescribed opioid frequency of the prescribed medication.

29. All controlled substances must be obtained at the same pharmacy, where possible, our office must be informed. Complete with your selected pharmacy:

Pharmacy:_____

Phone:_____

Patient Signature	Patient Name (Printed)	Date

Physician Signature	Date

PRECISION
PAIN MANAGEMENT

Behavioral Health Screening Questionnaire

Name: _____ Age: _____ Date: _____

Primary Care Physician: _____

Instruction: The following questionnaire should take less than 5 minutes to complete. This information is vital in your pain management care to better assist you in improving your ability to manage and cope with your pain. The questions address issues regarding how your pain may affect your emotional coping, stress, memory, and alcohol/substance abuse use. Please do your best to answer **every** question by circling either **YES** or **NO**. The questions relate to how you have been functioning over the past year unless otherwise indicated. **All information obtained on this questionnaire is confidential and will not be shared with anyone without your consent.**

Yes No I sometimes think that I or my family would be better off without me around.

Yes No I have **thought seriously** in the past year of harming myself

Yes No My pain is **significantly** affecting my relationships with my family

Yes No I cry more than I used to.

Yes No I find myself irritable, anxious, or nervous a great deal of the time.

Yes No My mood has been down since experiencing the pain.

Yes No My mood and my pain are directly related (My mood improves when my pain is less; my Mood is worse as my pain gets worse).

Yes No Also the **only** thing I think about is whether my pain will get better.

Yes No I am **certain** that my situation will never get any better.

Yes No I expect my pain to **always** be what it is now.

Yes No I feel like a burden to my family.

Yes No I sleep poorly not just due to the pain but also due to what's going through my mind.

Yes No I feel like I have no control over my life.

Yes No I have difficulty dealing with all the problems in my life.

Yes No There are times now that I feel that I am or about to panic.

Yes No When I feel panicky, my heart races, my hands tremble, or my hands get sweaty.

Yes No I sometimes drink too much.

Yes No I have a history of alcohol or drug problems.

Yes No I frequently have had more to drink or have taken more medication than I intend.

Yes No I have been treated for anxiety or depression sometimes in the past 2 years with medication or mental health treatment.

Yes No In the past year, I have had to deal with alcohol or drug problems brought on by family (children, spouse, parents, siblings) or a close friend.

Yes No I sometimes use marijuana, alcohol, another non-prescribed drug to help my pain.

Yes No I sometimes use marijuana, alcohol, another non-prescribed drug to help my nerves.

Yes No I would like to stop smoking cigarettes but first I need some help to do this.

Yes No I need to drink in order to express my feelings.

Yes No I become more depressed after I have sobered.

Yes No I typically have 3 or more drinks at least twice per week.

Yes No Do you currently have a psychologist? If yes, name: _____

Yes No Do you currently have a psychiatrist? If yes, name: _____

_____ _____

Patient Signature Date

PRECISION PAIN MANAGEMENT,LLC
HIPAA PRIVACY NOTICE

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. ♦PLEASE SIGN THE BACK OF THIS FORM♦

INTRODUCTION

Precision Pain Management,LLC and staff understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." "Protected health information" is also referred to as PHI. PHI includes any individually identifiable information that we obtain from you or others that relates your past, present or future physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI we maintain. You can always request a written copy of our most current privacy notice from the Practice's Privacy Officer.

PERMITTED USES AND DISCLOSURES

We can use or disclose your protected health information for purposes of treatment, payment and health care operations. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

♦ *Treatment* means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a post surgical care may need to know if you have diabetes because diabetes may slow the healing process.

♦ *Payment* means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we may need to provide information to your Third Party Payor about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the Third Party Payor for the services rendered to you, we can provide the Third Party Payor with information regarding your care if necessary to obtain payment. Federal or State law may require us to obtain a written release from you prior to disclosing certain specially PHI for payment purposes, and we will ask you to sign a release when necessary under applicable law.

♦ *Health care operations* means the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, computer maintenance and support, backup maintenance and support, development, management and administrative activities. For example, we may use your PHI to evaluate the performance of our staff when caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. In addition, we may remove information that identifies you from your patient information so that others can use the de-identified information to study health care and health care delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

In addition to using and disclosing your information for treatment, payment and health care operations, we may use your PHI in the following ways:

- We may disclose to your family or friends or any other individual identified by you PHI directly relevant to such person's involvement with your care or payment for your care. We may use or disclose your PHI to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are present or otherwise available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not present or otherwise available, we will determine whether a disclosure to your family or friends is in your best interest, taking into account the circumstances and based upon our professional judgment.
- We may disclose your PHI to a pharmacy on your behalf. As well as download /upload prescription information.
- We may contact you to provide appointment reminders for treatment or medical care or leave a message for you.
- When permitted by law, we may coordinate our uses and disclosures of PHI with public or private entities authorized by law or by charter to assist in disaster relief efforts.
- We will allow your family and friends to act on your behalf to pick-up prescriptions, medical supplies, X-rays, and similar forms of PHI, when we determine, in our professional judgment that it is in your best interest to make such disclosures.
- Subject to applicable law, we may make incidental uses and disclosures of PHI. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.
- Photographs, videotapes, digital, or other images may be recorded to document your care. The Practice will retain the ownership rights to these photographs, videotapes, digital, or other images, but you will be allowed access to view them or obtain copies. The images will be stored in a secure manner that will protect your privacy and that they will be kept for the time period required by law or outlined in the Practice's policy.
- We may use or disclose your PHI for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all patients who received a particular medication. All research projects are subject to a special approval process which balances research needs with a patient's need for privacy. When required, we will obtain a written authorization from you prior to using your health information for research.
- We will use or disclose PHI about you when required to do so by applicable law.

[Note: In accordance with applicable law, we may disclose your PHI to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer or the Practice as required by applicable law.]

SPECIAL SITUATIONS

Subject to the requirements of applicable law, we will make the following uses and disclosures of your PHI:

- Organ and Tissue Donation. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- Military and Veterans. If you are a member of the Armed Forces, we may release health information about you as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.
- Worker's Compensation. We may release health information about you for programs that provide benefits for work-related injuries or illnesses.
- Public Health Activities. We may disclose health information about you for public health activities, including disclosures:
  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products or services and to report reactions to medications or problems with products;

* to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
* to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if the patient agrees or when required or authorized by law.

- Health Oversight Activities. We may disclose health information to Federal or State agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government benefit programs, and compliance with civil rights laws or regulatory program standards.
- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if the Practice is given assurances that efforts have been made by the person making the request to tell you about the request or to obtain an order protecting the information requested.
- Law Enforcement. We may release health information if asked to do so by a law enforcement official:
  * In response to a court order, subpoena, warrant, summons or similar process;
  * To identify or locate a suspect, fugitive, material witness, or missing person;
  * About the victim of a crime under certain limited circumstances;
  * About a death we believe may be the result of criminal conduct;
  * About criminal conduct on our premises; and
  * In emergency circumstances, to report a crime, the location of the crime or the victims, or the identity, description or location of the person who committed the crime.
- Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner. Such disclosures may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.
- National Security and Intelligence Activities. We may release health information about you to authorized Federal officials for intelligence, counterintelligence, or other national security activities authorized by law.
- Protective Services for the President and Others. We may disclose health information about you to authorized Federal officials so they may provide protection to the President or other authorized persons or foreign heads of state or may conduct special investigations.
- Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual.

Note: HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records and other specially protected health information may enjoy certain special confidentiality protections under applicable State and Federal law. Any disclosures of these types of records will be subject to these special protections.

OTHER USES OF YOUR HEALTH INFORMATION

Other uses and disclosures of protected health information not covered by this notice or the laws that apply to us will be made only with your permission in a written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request. To request a restriction, you must make your request in writing to the Practice's Privacy Officer.
2. You have the right to reasonably request to receive confidential communications of protected health information by alternative means or at alternative locations. To make such a request, you must submit your request in writing to the Practice's Privacy Officer.
3. You have the right to inspect and copy the protected health information contained in your medical and billing records and in any other Practice records used by us to make decisions about you, except:

(i) for psychotherapy notes, which are notes that have been recorded by a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record;

(ii) for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;

(iii) for protected health information involving laboratory tests when your access is restricted by law;

(iv) if you are a prison inmate, obtaining a copy of your information may be restricted if it would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you;

(v) if we obtained or created protected health information as part of a research study, your access to the health information may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;

(vi) for protected health information contained in records kept by a Federal agency or contractor when your access is restricted by law; and

(vii) for protected health information obtained from someone other than us under a promise of confidentiality when the access requested would be reasonably likely to reveal the source of the information.

In order to inspect and copy your health information, you must submit your request in writing to the Practice's Privacy Officer. If you request a copy of your health information, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

We may also deny a request for access to protected health information if:

- a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person;
- the protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
- the request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person.

If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law. I authorize a copy of this form & my signature to be used in lieu of an original. This notice is effective 07/02/12.

Signature _____
If signed by patient representative, state relationship

Date ___/___/___ Relationship _____

PRECISION
PAIN MANAGEMENT

300 West Water Street, Suite A, Toms River, NJ 08753
PHONE 732 800-2760 FAX 732 505-5432

Letter to patients at Precision Pain Management...

Prescription narcotics continues to present a major healthcare concern and though opioid narcotics is a necessary and sole option for some patients I have decided to change the opioid prescribing policy at Precision Pain Management. There are many alternatives to narcotics available to you including abstinence, non-narcotics, anti- depressant and anti- seizure medications to name a few.

As you should be aware Governor Christie and the State of NJ have outlined and passed major reform regarding narcotic prescribing. This legislation despite affecting mostly patients with acute pain and initial prescriptions will have a major impact on patients receiving prescription opioids on a chronic basis.

I will remain committed to providing you state of the art interventional pain management as an alternative to opioids. At the same time, I will work with you to reduce or totally eliminate your narcotic usage. Precision Pain Management provides medical and implantable therapies to accomplish these goals. Should you require medical means of management my practice will assist you in attaining these medications.

While these changes will be unpopular and felt to be personal, please understand they are not. There are very few true indications for long term and chronic narcotic therapy. I am sure by working together in a healthy doctor patient relationship we can move your life in a healthy and opioid free direction.

Sincerely,

John A. Coccaro, MD

Please Read carefully and Sign!

Signature: _____

Print Name: _____ Date: _____