ADVANCED PAIN MANAGEMENT CENTER OF OKLAHOMA, LLC

Dear_____,

You have an appointment to see Dr._____on_____at_____.
We look forward to seeing you at Advanced Pain Management Center of Oklahoma, LLC, and working with you to evaluate and treat your pain. Please be 30 minutes early in order for us to process your paperwork. Please bring your insurance card with you and be prepared to pay your co-payment. We accept cash and all major credit cards. We do not accept personal checks.

Your initial visit will take place at the address listed below:

Advanced Pain Management Center of Oklahoma, LLC
3840 S 103rd East Ave Suite 100
Tulsa, OK 74146

A complete history of your problem is extremely important. Attached you will find your New Patient paperwork, which you need to read, fill out completely and sign. Failure to do so will delay your appointment and possibly cause your appointment to be rescheduled. Please bring your completed paperwork and insurance card to your appointment.

In order to allow appropriate time and avoid inconveniencing our other patients we have the following office policies:

1. If you are more than 10 minutes late for your appointment, we may reschedule your appointment.
2. If you fail to show for an appointment on two occasions without having called us to cancel the appointment by the day before, we will dismiss you from the practice.

INSTRUCTIONS FOR PROCEDURE APPOINTMENTS ONLY

- Nothing to eat 6 hours prior to your appointment.
- No liquids of any kind 4 hours prior to your appointment.
- Take your usual medication with a sip of water.
- Bring a driver.
- If you are taking any of the following medications, please contact a member of our medical staff at (918) 921-9700: Insulin, Glucophage, or any blood thinners (i.e. Coumadin, Plavix)

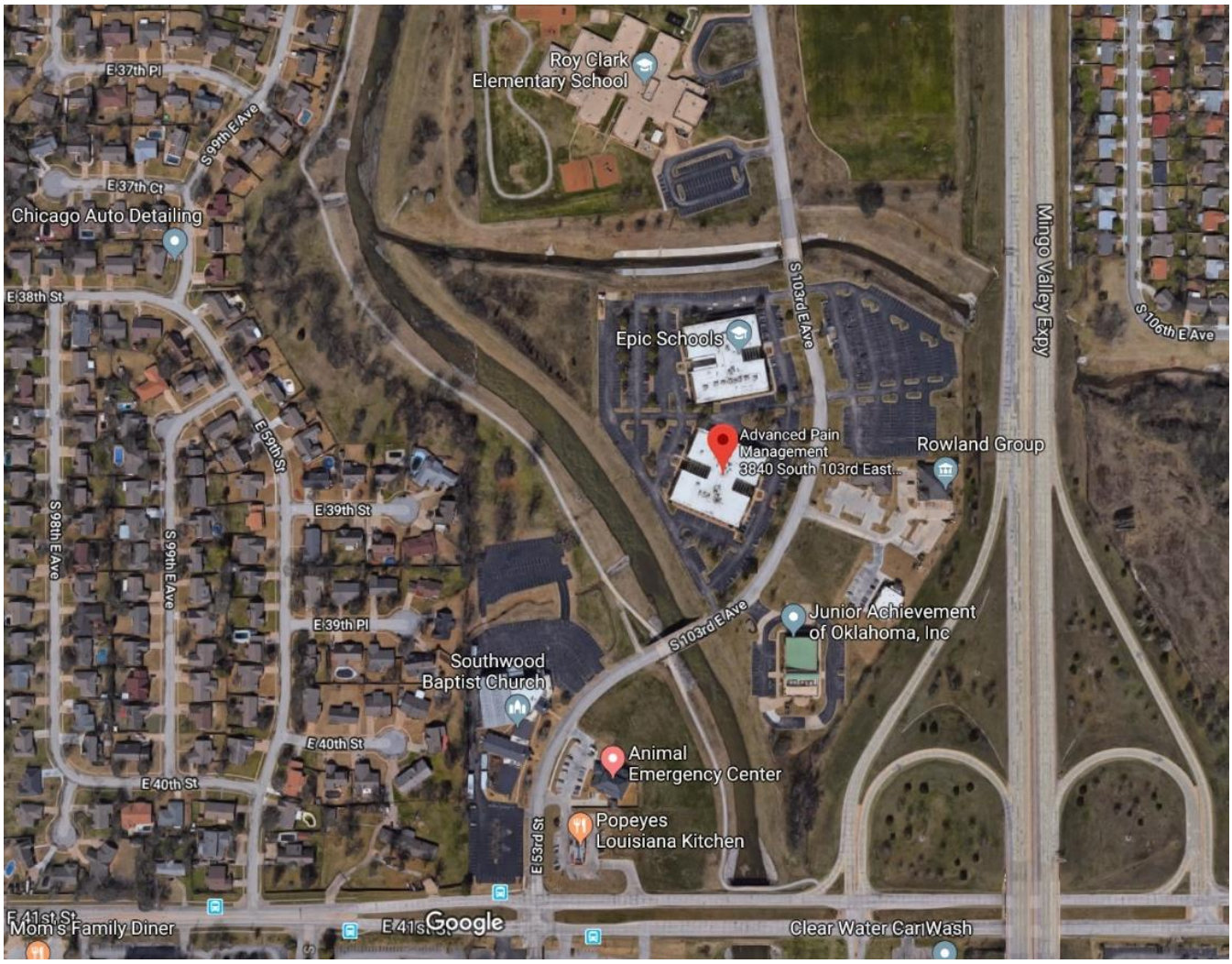
FAILURE TO FOLLOW THESE INSTRUCTIONS MAY RESULT IN RESCHEDULING YOUR PROCEDURE!

Thank you for allowing the physicians and staff of Advanced Pain Management Center of Tulsa to be of service to you. Should you have any questions, please feel free to contact us at 918-921-9700 between the hours of 8:00am and 4:45pm Monday thru Thursday and 8:00am and 1pm on Friday (excluding holidays).

See you Soon!

Advanced Pain Management Center of Oklahoma, LLC

Advanced Pain Management Center of Oklahoma, LLC
3840 S 103rd East Ave, Suite 100
Tulsa, OK 74146
918-921-9700



Dear Patient:

Welcome to Advanced Pain Management Center of Oklahoma, LLC (APMC). We appreciate the confidence and trust you have placed in us by scheduling an appointment, and we look forward to seeing you. Our philosophy is to help you best manage your chronic or current pain symptom. We shall make every effort to see that your experience with our clinic is as comfortable as possible.

At your initial appointment, the provider will take a complete history. **Please provide our office with copies of any reports from previous tests such as MRI, CT, EMG, bone scans, X-Rays and any other diagnostic testing for your current problem.** Your physician needs this information to assist in your treatment.

Due to the amount of time that our providers may need to spend with you at your initial consultation, we cannot allow small children to accompany you into the treatment areas. Please bring a responsible adult along to watch children during your appointment. If this is not possible, we will need to reschedule your appointment to a more appropriate time.

Follow up visits may be scheduled with a nurse practitioner or physician's assistant who works closely with your physicians. They are a very important part of our Advanced Pain Management Center team and will make every effort to help you manage your pain.

Since all insurance company policies are different, it is advisable that you become familiar with your particular insurance coverage. This allows us to assist you in obtaining your maximum benefits. Any co-payment is due at the time of service, and we ask that you bring this with you to your appointment. **For quality purposes you may be asked to show a staff member your insurance card and government issued photo ID. Please bring to each visit.**

If you have already prepared an Advance Directive, please bring a copy to your visit and we will place it in your medical record.

Please arrive 30 minutes prior to your scheduled appointment time. We will make every effort to maintain our schedule and yours. Please assist us by being punctual. If you are unable to keep your appointment, we ask that you give us at least 48 hour notice.

If you have any questions about APMC and/or the conditions we treat, please visit our website at **www.ampcok.com**. To view full animation of the procedures we offer, click on the "Conditions and Treatments" tab.

Thank you for choosing us. We welcome any questions or concerns you may have, and we look forward to seeing you.

Sincerely,

Advanced Pain Management Center of Oklahoma, LLC

INFORMED CONSENT FOR OPIOID TREATMENT

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician/health care provider comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

I have agreed to use opioids as part of my treatment for chronic pain. I understand that these drugs can be very useful but have a high potential for misuse and are therefore closely controlled by the local, state, and federal government. Because my physician/ health care provider is prescribing such medication to help manage my pain, I agree to the following conditions:

1. I am responsible for my pain medications. I agree to take the medication only as prescribed.
   a. I understand that increasing my dose without the close supervision of my physician could lead to drug overdose causing severe sedation and respiratory depression and death.
   b. I understand that decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal. Withdrawal symptoms can include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh", abdominal cramps, and diarrhea. These symptoms can occur 24-48 hours after the last dose and can last up to 3 weeks.

2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician/health care provider at the Pain Center.

3. 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 of any side effects that continue or are severe (i.e., sedation, confusion). I am also responsible for notifying my pain physician immediately if I need to visit another physician or need to visit an emergency room due to pain, or if I become pregnant.

4. I understand that the opioid medication is strictly for my own use. The opioid should never be given or sold to others because it may endanger that person's health and is against the law.

5. I should inform my physician of all medications I am taking, including herbal remedies. Medications like Valium or Ativan; sedatives such as Soma, Xanax, Fiorinal; antihistamines like Benadryl; herbal remedies, alcohol, and cough syrup containing alcohol, codeine, or hydrocodone can interact with opioids and produce serious side effects.

6. I understand that opioid prescriptions will not be mailed. If I am unable to obtain my prescriptions monthly, I will be responsible for finding a local physician who can take over the writing of my prescriptions with consultations from my pain physician.

7. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.

8. I will communicate fully with my physician to the best of my ability at the initial and all follow-up visits about my pain level and functional activity along with any side effects of the medications. This information allows your physician to adjust your treatment plan accordingly.

9. You should not use any illicit substances, such as cocaine, marijuana, etc. while taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship.

10. The use of alcohol together with opioid medications is contraindicated.

11. I am responsible for my opioid prescriptions. I understand that:
    a. Refill prescriptions can be written for a maximum of one month supply and will be filled at the same pharmacy.
    Pharmacy:_____Phone number: _____
    b. It is my responsibility to schedule appointments for the next opioid refill before I leave the clinic or within 3 days of the last clinic visit.
    c. I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. I will then report the stolen medication to my physician. If my medications are lost, misplaced, or stolen my physician may choose not to replace the medications or to taper and discontinue the medications.
    d. Refills will not be made as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow".
    e. Refills can only be filled by a pharmacy in the State of Oklahoma, even if I am a resident of another state.
    f. Prescriptions for pain medicine or any other prescriptions will be done only during an office visit or during regular office hours. No refills of any medications will be done during the evening or on weekends.
    g. You must bring back all opioid medications and adjunctive medications prescribed by your physician in the original containers/bottles at every visit.
    h. Prescriptions will not be written in advance due to vacations, meetings, or other commitments.
    i. If an appointment is *missed*, another appointment will be made as soon as possible. *Immediate* or *emergency* appointments will not be granted.
    j. No "walk-in" appointments for opioid refills will be granted.

12. While physical dependence is to be expected after long-term use of opioids, signs of addiction, abuse, or misuse shall prompt the need for substance dependence treatment as well as weaning and detoxification from the opioids.

    a. Physical dependence is common to many drugs such as blood pressure medications, anti-seizure medications, and opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal response. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.

    b. Addiction is a primary, chronic neuro biologic disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the

following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life. If the patient exhibits such behavior, the drug will be tapered and such a patient is not a candidate for an opioid trial. He/she will be referred to an addiction medicine specialist.

c. Tolerance means a state of adaptation in which exposure to the drug induces changes that result in a lessening of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a *realistic* decrease of the patient's pain.

13. If it appears to the physician/health care provider that there is no improvement in my daily function or quality of life from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed by the physician.

14. If I have a history of alcohol or drug misuse/addiction, I must notify the physician of such history since the treatment with opioids for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery is a necessity.

15. I will be seen on a monthly basis and given prescriptions for enough medication to last from appointment to appointment, and sometimes two to three days extra if the prescription ends on a weekend or holiday. This extra medication is not to be used without the explicit permission of the prescribing physician unless an emergency requires your appointment to be deferred one or two days.

16. I agree and understand that my physician reserves the right to perform random or unannounced urine drug testing. If requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my doctor may change my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the doctor/patient relationship. The presence of a non-prescribed drug (s) or illicit drug (s) in the urine can be grounds for termination of the doctor/patient relationship. Urine drug testing is not forensic testing, but is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.

17. I agree to allow my physician/health care provider to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions *if the physician feels it is necessary*.

18. I agree to a family conference or a conference with a close friend or significant other *if the physician feels it is necessary*.

19. I understand that non-compliance with the above conditions may result in a re-evaluation of my treatment plan and discontinuation of opioid therapy. I may be gradually taken off these medications, or even discharged from the clinic.

I_____have read the above information or it has been read to me and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy &acknowledge receipt of this document.

Patient's Signature_____ Date_____

Witness's Signature_____ Date_____

Patient Registration

Name:		Social Security Number:	
Address:			
Phone:	Email:	Sex:	Date of Birth:
Employer:	Occupation:	Martial Status:	
Pharmacy:	Pharmacy Phone:	Pharmacy Address:	
Referring Doctor:			
Emergency Contact:	Relationship:	Phone Number:	

Responsible Party

Name of Responsible Party:	Relationship:	
Date of Birth:	Social Security Number:	Phone Number:
Address:		
Employer:	Occupation:	Work Number:

Insurance Information

Primary Insurance:	Subscriber:	Date of Birth:	Social Security Number:
Billing Address:			
Employer:	Insurance ID #:	Group #:	
Secondary Insurance:	Subscriber:	Date of Birth:	Social Security Number:
Billing Address:			
Employer:	Insurance ID#:	Group #:	
Is your injury work related?		Is your treatment personal injury related?	

Assignment and Release

I hereby certify the above information is true and correct to the best of my knowledge. I understand that while Advanced Pain Management Center of Oklahoma, LLC contracts with many insurance companies, it is my responsibility to verify with my plan that Advanced Pain Management Center of Tulsa is a participating provider. It is also my responsibility to find out what my coverage options are with my insurance plan. I further understand that Advanced Pain Management Center of Oklahoma, LLC will assist me in obtaining authorization from my primary care physician or insurance company if necessary. If however, authorization is not obtained, I may be financially responsible for services rendered. I hereby authorize Advanced Pain Management Center of Tulsa to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of insurance coverage. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPAA guidelines.

Patient Signature:	Date:

NEW PATIENT EVALUATION FORM

Date form completed:_____

918-921-9700• www.apmcok.com

GENERAL INFORMATION

Patient Name:

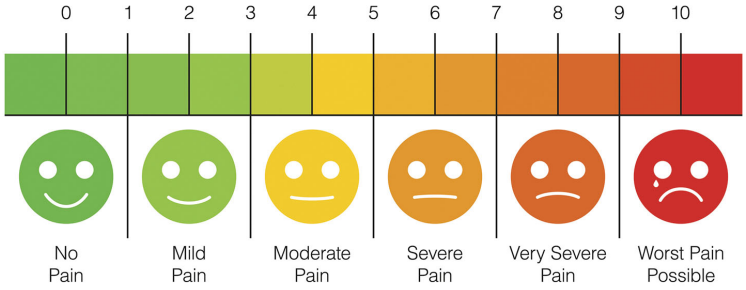
Date of birth: ____/____/_____

Referred By: _____ Family Physician: _____

Date onset of pain: _____ □ Sudden □ Gradual Cause of pain:_____

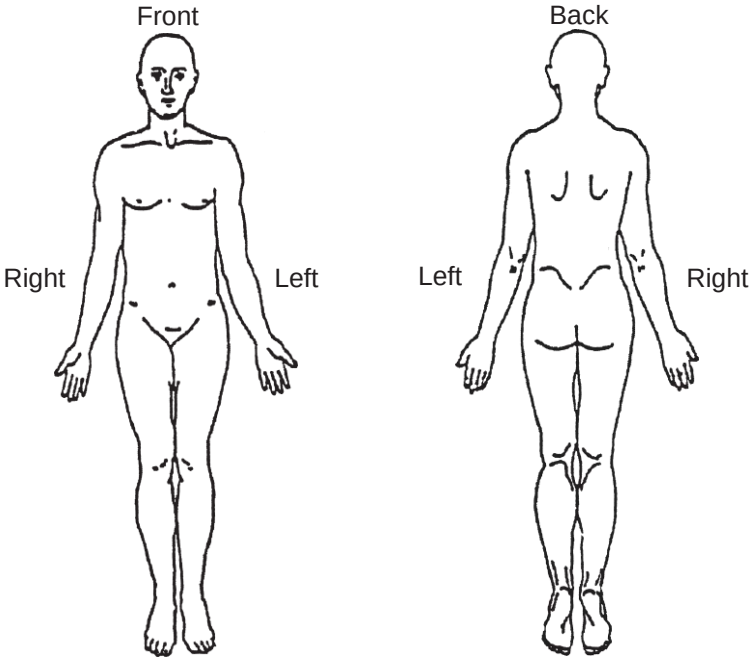
On a scale of 1-10: Your pain at its **worst** over the last month:_____ Your pain at its **best** over the last month:_____
Your pain today: ____

PAIN SCALE



LOCATION OF YOUR PAIN

On the picture, color in all your areas of pain.



Associated with (check all that apply):

- ☐ Numbness/Tingling
- ☐ Night Pain
- ☐ Weakness
- ☐ Loss of Control of Bowel
- ☐ Loss of Control of Bladder
- ☐ Fever/Chills
- ☐ Sexual Dysfunction
- ☐ Unexplained Weight Loss

How many pounds: ☐

Patient Name:

Date of birth: / /

SYMPTOMS The questions below refer only to the area of pain that you are coming to our clinic for at this time.

My pain is: ☐ Mild ☐ Mild-Moderate ☐ Moderate ☐ Moderate-Severe ☐ Severe

Check the boxes that best describe what your pain feels like.

☐ Throbbing	☐ Shooting	☐ Stabbing	☐ Burning	☐ Sharp	☐ Tingling
☐ Numb	☐ Tender	☐ Pressure	☐ Deep	☐ Aching	☐ Cramping
☐ Heaviness	☐ Diffuse	☐ Dull	☐ Gnawing	☐ Localized	☐ Superficial

What makes your pain worse?

☐ Bending	☐ Coughing	☐ Daily Activities	☐ Driving	☐ Everything	☐ First Steps
☐ Going Downstairs	☐ Going Upstairs	☐ Kneeling	☐ Lifting	☐ Lying Down	☐ Neck Movement
☐ Nothing	☐ Reaching	☐ Sitting	☐ Sneezing	☐ Squatting	☐ Standing
☐ Stretching	☐ Twisting	☐ Weather Changes	☐ Walking		☐ Work Activities
☐ Other, Explain					

The pain is: ☐ At Rest ☐ Continuous ☐ In the Night ☐ In the Morning ☐ Intermittent ☐ With Activity ☐ Spontaneous

Does your pain make you: (check all that apply)

☐ Depressed
☐ Helpless/Hopeless
☐ Angry
☐ Frustrated

Does your pain interfere with any of the following

☐ Sleep ☐ Daily Activities ☐ Work

Patient Name:_____ DOB: _____

Please review the following list and check any that apply to you.

Constitutional
□ Normal □ Abnormal

- Weight Loss □
- Weight Gain □
- Fever □
- Chills □
- Insomnia □
- Fatigue □

Eyes
□ Normal □ Abnormal

- Vision □
- Pain □
- Dryness □
- Glaucoma □

Ears, Nose & Throat
□ Normal □ Abnormal

- Hearing Loss □
- Tinnitus (ringing in ears) □
- Vertigo □
- Dizziness □
- Nasal Congestion □
- Sinus Pain □
- Decreased Smell □
- Epistaxis (nose bleeds) □
- Sore throat □
- Dysphagia (trouble swallowing) □

Respiratory
□ Normal □ Abnormal

- Shortness of Breath □
- Cough □
- COPD □
- Asthma □
- Hemoptysis (bloody Sputum) □
- Wheezing □
- Chest Pain □
- Snoring □
- Lung Problems □

Cancer
□ Current □ Remission

- Breast □
- Bone □
- Kidney □
- Lung □
- Pancreatic □
- Other:_____ □

Musculoskeletal
□ Normal □ Abnormal

- Joint Pain □
- Arthritis □
- Neck Pain □
- Mid Back Pain □
- Low Back Pain □
- Leg Pain □
- Arm Pain □
- Lupus □
- Rheumatoid Arthritis □

Neuro
□ Normal □ Abnormal

- Headaches □
- Stroke □
- Fainting □
- Seizures □
- Paralysis □
- Clumsiness □
- Memory Loss □
- Numbness □

Psychiatric
□ Normal □ Abnormal

- Depression □
- Anxiety □
- Suicidal □
- Hallucinations □
- Bi-Polar □
- Schizophrenic □

Genitourinary
□ Normal □ Abnormal

- Incontinence □
- Dysuria (pain w/ urination) □
- Urgency □
- Hematuria (blood in urine) □
- Erectile Dysfunction □
- Loss of Sexual Drive □
- Kidney Infections □

Allergic/Immunologic
□ Normal □ Abnormal

- Food Allergies □
- Environmental Allergies □
- HIV □
- AIDS □
- Immune Disorder □

Hematologic/Lymphatic
□ Normal □ Abnormal

- Easy Bruising □
- Easy Bleeding □
- Lymphadenopathy □
- Blood Clots □

Skin/Dermatologic
□ Normal □ Abnormal

- Rash □
- Dryness □
- Alopecia (hair loss) □
- Nail Changes □
- Color Changes □
- Eczema □

Gastrointestinal/Heptatic
□ Normal □ Abnormal

- Abdominal Pain □
- Vomiting □
- Diarrhea □
- Constipation □
- Bloody Stool □
- Nausea □
- Ulcers □
- Liver Problems □
- Hepatitis A □
- Hepatitis B □
- Hepatitis C □

Endocrinology
□ Normal □ Abnormal

- Diabetes Type I □
- Diabetes Type II □
- Diaphoresis □
- Thyroid Problems □

Cardiovascular
□ Normal □ Abnormal

- Chest Pain □
- Shortness of Breath □
- Palpitations □
- Claudication □
- High Blood Pressure □
- Heart Problems □
- Heart Attack □
- Congestive Heart Failure □

Please list all injuries:

Year	Type	Body Part

Please list all past surgeries:

Year	Surgery	Surgeon

Previous Pain Treatments Tried (Check all that apply):

□ Injections	□ Acupuncture	□ Chiropractor
□ Occupational Therapy	□ Pain Psychology	□ Physical Therapy
□ Tens Unit	□ Spinal Cord Stimulation	□ Surgery

Previous Imaging/ Tests:

Type	Date	Place
□ Lumbar MRI		
□ Thoracic MRI		
□ Cervical MRI		
□ Discogram		
□ EMG		
□ Other: _____		

Patient Name:

Date of birth: ____/____/_____

ALLERGIES

ALLERGY	REACTION

MEDICATION HISTORY

Pharmacy Name: Phone#:

Please provide a list of current prescription medication and over the counter medication:

MEDICATION NAME	DOSE	FREQUENCY	PHARMACY

Have you taken any medications in the past for your current pain problem, even if they didn't work? ☐ Yes ☐ No

If yes, please list (be sure to include any nonprescription medications such as Tylenol, Bengay, etc.)

NAME	WHY STOPPED

Patient Name:

Date of birth: ____/____/_____

WORK HISTORY

Are you employed?	☐ Yes ☐ No
Occupation:	
If yes, where:	
Are you on worker's compensation?	☐ Yes ☐ No
Is your employer contesting?	☐ Yes ☐ No
Do you have an attorney?	☐ Yes ☐ No
If yes, attorney name:	
When did you last work? ____/____/_____	
Are you currently working?	☐ Yes ☐ No
Do you have work restrictions?	☐ Yes ☐ No
Would you return to work with restrictions?	☐ Yes ☐ No
Have you missed work because of your pain?	☐ Yes ☐ No
Do you want to go back to work?	☐ Yes ☐ No
Do you want permanent disability?	☐ Yes ☐ No

PSYCHOLOGICAL HISTORY

Have you ever been treated for emotional/behavioral disorder?	☐ Yes ☐ No
Have you ever been treated for depression?	☐ Yes ☐ No
If yes, when:	
Do you currently have ACTIVE suicidal thoughts?	☐ Yes ☐ No
Do you have a history of suicidal attempts?	☐ Yes ☐ No
Do you have a history of drug abuse?	☐ Yes ☐ No
Do you have a history of alcohol abuse?	☐ Yes ☐ No

Patient Name: Date of birth:

____/____/_____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow	
Do you have Children?	
If yes, how many:	☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No If yes, how many packs a day?	
Are you a former smoker? ☐ Yes ☐ No	Quit date? -_____
Do you drink alcohol? ☐ Yes ☐ No	How much in a week? _____
Have you ever been arrested or convicted on a drug related charge?	☐ Yes ☐ No
If yes, please explain:	

ADDITIONAL INFOMATION

If you are 65 or older have you ever had a pneumococcal vaccine?	☐ Yes ☐ No
Do you get a yearly flu shot?	☐ Yes ☐ No
If yes, when was your last one: _____	
Do you have a care plan?	☐ Yes ☐ No
Living Will	☐ Yes ☐ No
DNR (Do not resuscitate)	☐ Yes ☐ No
Do not want to discuss	☐ Yes ☐ No

I, the undersigned, have completed this form and the information that I have provided is true and accurate to the best of my knowledge. I understand that this information is used in my care and treatment plan while under the care of the Advanced Pain Management Center of Tulsa, PLLC.

Patient/Guardian Signature _____ Date: ____/____/_____

ADVANCED PAIN MANAGEMENT

Patient Name: Date of birth: ____/____/_____

Please complete this questionnaire. It has been designed to give us information as to how your pain has affected your ability to manage in everyday life. **Please answer every section**. Mark only ONE number in each section that most closely describes you today.

Section 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 - Personal Care

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself, but it is very painful.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help, but can manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on the table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ Pain prevents me from walking more than 100 yards.
- ☐ I can walk only using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 - Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want, but it gives me extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 1/2 hour.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 - Sleeping

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain, I have less than 6 hours of sleep.
- ☐ Because of pain, I have less than 4 hours of sleep.
- ☐ Because of pain, I have less than 2 hours of sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 - Sex Life (if applicable)

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal, but causes some extra pain.
- ☐ My sex life is nearly normal, but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is absent because of pain.
- ☐ Pain prevents any sex life at all.

Section 9 - Social Life

- ☐ My social life is normal and causes me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g., sports, etc.)
- ☐ Pain has restricted my social life and I don't go out often.
- ☐ Pain has restricted my social life to home.
- ☐ I have no social life because of pain.

Section 10 - Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere, but it gives me extra pain.
- ☐ Pain is bad, but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to short journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment.

Investigator's signature: Total:

Date: ____/____/_____

PATIENT HEALTH QUESTIONNAIRE 9 (PHQ 9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	0 ☐	1 ☐	2 ☐	3 ☐

FOR OFFICE CODING *0* **+**_____**+**_____**+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Patient Financial Statement of Information

Thank you for choosing Advanced Pain Management Center of Oklahoma, LLC (APMCOK) as your pain provider. Advanced Pain Management Center is a caring organization that is committed to providing patients with innovative pain management services. We are committed to providing you with quality and affordable health care.

Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have and sign in the space provided. A copy will be provided to you upon request.

Insurance and Billing

- As your provider, please remember that our relationship is with you and not your insurance company. Your benefit coverage is a contract between you and your insurance carrier. Please be aware that not all medical services are covered benefits under all insurance contracts. We encourage you to be familiar with your insurance benefits and limitations. If you have any questions about your insurance coverage, please contact your insurance carrier directly.
- Our physicians are "Preferred Providers" for many insurance plans. It is your responsibility to check with your insurance carrier to ensure that the Advanced Pain Management Center physician(s) and /or facility participate with your insurance network. If Advanced Pain Management Center is not in your carrier's network, you may incur higher patient responsibility amounts.
- As a service to you, our office will bill your health insurance company. Providing us with accurate information at the time services are rendered will facilitate in the timely filing of claims. Changes in your information should be reported to our office in a timely manner. Your cooperation in keeping your account information current is greatly appreciated.

- If you undergo urine toxicology testing, you will receive an invoice from APMCOK for the test. In addition, many of our lab results are also sent to a confirmatory lab for additional information on the quantitative results of the specimen. If your test is sent to a confirmatory lab, you will receive a separate bill for their services.
- If you receive services in a Hospital or other inpatient setting, you will receive a separate bill for those Facility charges, separately from any bills you may receive for services provided by an APMC provider or facility.

Co-payments, Co-insurance and Deductibles

All copayments, coinsurance and deductibles are due at the time of service.

Co-payments are a flat fee paid each time a medical service is accessed and must be paid before any policy benefit is payable by an insurance company. Co-payments usually range from $20.00 to $50.00 depending on your coverage.

Co-insurance is a percentage of the allowed charge that the patient pays after the deductible has been satisfied.

Deductibles are amounts which must be paid out of pocket before an insurance carrier will pay any expenses. The deductible must be paid by the patient before the benefits of the insurance policy can apply.

Our providers are in network with most insurance companies, and the insurance company will require that we collect these fees per the terms of your health care contract. Failure to pay any amounts due, including past due balances, will result in your appointment being rescheduled or other collection activity. Please speak with one of our financial counselors if you need assistance with the payments of these balances. For your convenience, we accept cash, checks (bill payment only), debit or credit cards (MasterCard, Visa, Discover and American Express). A fee of $35.00 will be charged for all returned checks.

Self-Pay

If you are uninsured and are in need of care, we can see you on a self pay basis. Payment is due at the time services are rendered.

Referrals/Authorizations

Many of the services we provide require referrals, authorization and pre-authorization. Your insurance company may require documentation prior to authorizing services and we will do our best to comply in a timely fashion with their requests. This process can take time. We appreciate your patience while we work with your insurance company. We reserve the right to refuse or reschedule services to any patient who does not have a valid referral in our office at the time of their appointment.

Hardship

A Hardship Discount may be available to our patients who do not have the ability to pay their bills. We will require that you complete a financial statement and provide information including your last year's tax filings. Please contact us at **918-921-9700**, if you believe you may qualify for this program.

Non-Payment

If your account is over 120 days past due, your account will be referred to our outside collection agency. This may include listing your information with the credit bureau. Your account will also be reviewed for possible discharge from care.

Overpayment

Patients agree that if they have a credit balance after paying for a service, Advanced Pain Management Center can apply this credit to any outstanding balance on their account, including balances related to professional or facility fees. Patients will be refunded any amounts paid in excess after all outstanding amounts have been credited.

Cancellation of Services

Advanced Pain Management Center reserves the right to charge a $50 fee if the patient fails to provide at least 24 hours cancellation notice. This fee will be paid by the patient regardless of insurance.

You may see balances on your statement(s) that are related to previous services performed at Advanced Pain Management Center. Please be advised that these balances must be paid immediately. You may pay by speaking with one of our customer service representatives or by mailing in your payment.

Non-covered Services:

The following services are considered "Non-Covered Services" by most insurance companies. The fees listed below must be paid at the time of service.

- Returned Checks: If your check is returned to us for any reason, you will be charged $35.
- Missed Appointments: If you fail to notify us at least 24 hours in advance that you will not be able to make your appointment, we may charge you $50.
- Forms Completion: Disability, Insurance Forms, Travel Forms, Release from Work, and other forms that are not required by your insurance plans. If you request our office to complete these forms, there will be a $35 charge.
- Paper Records: We will provide to you, upon written request, a paper copy of your medical record. The charge will be $1.00 for the first page, $.50 each additional page, and actual postage. Maximum charge $50.00
- Phone Visits: If you request medical services via telephone afterhours, the following fees apply. You must be an established patient to request this service. If the phone visit results in an office visit within 24 hours, you will be refunded, per Federal insurance guidelines.
    - 5-10 minutes: $30
    - 11-20 minutes: $45
    - 21-30 minutes: $60
- Late Fees: Invoices not paid within 60 days will result in a $5 per month late fee.
- Co-pay Collection Fee: If we must bill you for your copay, you may be required to pay a $20 Co- pay Collection fee.

I have read and understand the Advanced Pain Management Center of Tulsa, LLC Financial Policy. I agree to assign insurance benefits to Advanced Pain Management Center of Tulsa, LLC whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency for costs of collections.

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Advanced Pain Management Center ("APMC") is committed to ensuring that your health information is kept private in accordance with federal and state law. This information is called "protected health information" or "PHI." This Notice covers the privacy practices of all health care professionals, employees and staff at our APMC clinic. We will abide by the terms of the Notice.

We are required by law to maintain the privacy of your PHI and to provide you with this Notice. We are also required to notify you following a breach of your unsecured health information.

This Notice is effective as of May 1, 2016. We reserve the right to make changes to this Notice as permitted by law. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. Each version of the Notice will have an effective date listed on the first page. If we change this Notice, you can access the revised Notice using these options:

- From the APMC website (www.apmcok.com); or
- From the receptionist at APMC clinic.

If you want more information about the privacy practices of APMC, please contact the Advanced Pain Management Center Privacy Officer in writing at 3840 S 103rd East Ave, Tulsa, OK 74146or by email at asalguero@apmcok.com

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION: *The following categories describe the ways that we may use and disclose your PHI without your written authorization:*

Treatment. We will use PHI about you to provide you with medical treatment or services. We will disclose your PHI to other health care professionals so that they can evaluate your health, diagnose your medical conditions and provide your treatment. For example, results of laboratory tests and procedures will be available in your medical record to health professionals who may need the information to provide you with treatment.

Payment. We may use and disclose your PHI to obtain payment for the services we provide to you. For example, we may disclose your PHI to seek payment from your insurance company, or from another third party. We may need to give your insurance company information about a procedure you underwent so that your insurance company will pay for the procedure We may also inform your insurance company about a treatment you are going to receive so that we obtain prior approval for the treatment, or in order to find out if your insurance company will cover the treatment.

Health Care Operations. We may use and disclose your PHI in order to conduct certain of our business activities, which are called health care operations. These uses and disclosures are necessary to run our business and make sure our patients receive quality care. For example, we may use your health information for quality assessment activities, necessary credentialing, and for other essential activities. We may also disclose your health information to third party "business associates" that perform various services on our behalf, such as transcription, billing and collection services. In these cases, we will enter into a written agreement with the business associate to ensure they protect the privacy of your health information.

OTHER WAYS WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION: *The following categories describe other ways we may use and disclose your PHI without your written authorization.*

Family Members and Friends for Care and Payment and Notification If you verbally agree to the use or disclosure and in certain other situations, we may make the following uses and disclosures of your PHI. We may disclose certain PHI to a family member, friend, or anyone else whom you identify as involved in your health care or who helps pay for your health care. In such cases, the PHI we disclose would be limited to the portion of the PHI that is relevant to that person's involvement in your care or payment for your care. We may also make these disclosures after your death as authorized by Oklahoma law unless doing so is inconsistent with any prior expressed preference. We may use or disclose your PHI to notify or assist in notifying a family member, personal representative, or any other person responsible for your care regarding your location, general condition, or death. In an emergency situation or in the event of your incapacity, we may exercise our professional judgment to determine whether a disclosure to a particular person is in your best interest.

Fundraising. We may use your demographic information (such as name, contact information, age, gender, and date of birth), the dates you received services from us, the department of your service, your treating physician, outcome information, and health insurance status to contact you about supporting our fundraising efforts. You may opt out of receiving any further fundraising communications from us.

Disaster Relief Efforts. We may disclose your PHI to organizations for the purpose of disaster relief efforts in accordance with the law.

Required by Law. We may disclose your PHI when required by law to do so.

Public Health Reporting. We may disclose your PHI to public health agencies as authorized by law. For example, we may report certain communicable diseases to the state's public health department.

Reporting Victims of Abuse or Neglect. If we reasonably believe you have been a victim of abuse or neglect, we may disclose your PHI to a government authority in accordance with law.

Health Care Oversight. We may disclose your PHI to authorities and agencies for oversight activities allowed by law, including audits, investigations, inspections, licensure and disciplinary actions, or civil, administrative and criminal proceedings, as necessary for oversight of the health care system, government programs and civil rights laws.

Legal Proceedings. We may disclose your PHI pursuant to a court order if you are involved in a legal proceeding. Under most circumstances when the request is made through a subpoena, a discovery request, or involves another type of administrative order, your authorization will be obtained before disclosure is permitted.

Law Enforcement. We may disclose your PHI to a law enforcement official for certain specific purposes, such as reporting certain types of injuries.

Deceased Persons. We may disclose your PHI to coroners, medical examiners or funeral directors so that they can carry out their duties.

Research. Under certain circumstances, we may disclose your PHI to researchers who are conducting a specific research project. For certain research activities, an Institutional Review Board (IRB) or Privacy Board may approve uses and disclosures of your PHI without your authorization.

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI if we believe it is necessary to prevent a serious and imminent threat to the health or safety of a person or to the public.

Military, National Security, or Incarceration/Law Enforcement Custody. If you are or were involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your PHI to the proper authorities so they may carry out their duties under the law

Workers' Compensation. We may disclose your PHI as necessary to comply with laws related to workers' compensation or other similar programs.

Please be aware that Oklahoma law and other federal laws may have additional requirements that we must follow, or may be more restrictive than HIPAA on how we use and disclose your PHI. If there are specific more restrictive requirements, even for some of the purposes listed above, we may not disclose your PHI without your written permission as required by such laws. For example, we will not disclose your HIV test results without obtaining your written permission, except as permitted by Wisconsin law. We may also be required by Oklahoma and or federal law to obtain your written permission to use and disclose your information related to treatment for a mental illness, developmental disability or alcohol or drug abuse.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION
Disclosure of your PHI or its use for any purpose other than those listed above requires your specific written authorization. Some examples include:

- Psychotherapy Notes: We usually do not maintain psychotherapy notes about you. If we do, we will only use and disclose them with your written authorization except in limited situations.
- Marketing: We may only use and disclose your health information for marketing purposes with your written authorization
  This would include making treatment communications to you when we receive a financial benefit for doing so.

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If you change your mind after authorizing a use or disclosure of your PHI, you may withdraw your permission by revoking the authorization However, your decision to revoke the authorization will not affect or undo any use or disclosure of your PHI that occurred before you notified us of your decision, or any actions that we have taken based upon your authorization. To revoke an authorization, you must notify us in writing at Advanced Pain Management Center, ATTN: Privacy Officer, 3840 S 103rd East Ave, Tulsa, OK 74146

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

YOUR PROTECTED HEALTH INFORMATION RIGHTS
As an APMC patient, you have the following rights regarding the PHI we maintain about you:

Right to Inspect and Copy. You have the right to inspect and receive a copy of your PHI. We may charge you a fee as authorized by law to meet your request. To inspect and copy your health information, you must make your request in writing. Please contact our Medical Records Department at 918-921-9700 to obtain a request form. You may request access to your medical information in a certain electronic form and format, if readily producible, or, if not readily producible, in a mutually agreeable electronic form and format. Further, you may request in writing that we transmit such a copy to any person or entity you designate. Your written, signed request must clearly identify such designated person or entity and where you would like us to send the copy. If you wish to make such requests, please contact Medical Records Department at 918-921-9700.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. You have a right to request that we amend or correct your PHI that you believe is incorrect or incomplete. For example, if your date of birth is incorrect, you may request that the information be corrected. To request a correction or amendment to your PHI, you must make your request in writing to Medical Records Department, Supervisor, Advanced Pain Management Center, 3840 S 103rd East Ave, Tulsa, OK 74146and provide a reason for your request. You have the right to request an amendment for as long as the information is kept by or for us. Under certain circumstances we may deny your request. If your request is denied, we will provide you with information about our denial and how you can file a written statement of disagreement with us that will become part of your medical record.

Right to Request Restrictions on Certain Uses and Disclosures. You have the right to request restrictions on how your PHI is used or disclosed for treatment, payment or health care operations activities. However, we are not required to agree to your requested restriction, unless that restriction is regarding disclosure of PHI to your health insurance company and: (1) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (2) the PHI pertains solely to a health care item or service for which you or another person (other than your health insurance company) paid for in full. If you would like to make a request for a restriction, you must submit your request in writing to Medical Records Department, Supervisor, Advanced Pain Management Center, 3840 S 103rd East Ave, Tulsa, OK 74146If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

The Right to Request Confidential Communications. You have the right to request that we communicate your PHI to you in a certain manner or at a certain location. For example, you may wish to receive information about your health status through a written letter sent to a private address. We will grant reasonable requests. We will not ask you the reason for your request. To request confidential communications, you must make your request in writing. You may obtain a request form by contacting our Medical Records Department at 918-921-9700.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures we make of your PHI. Please note that certain disclosures need not be included in the accounting we provide to you. To request an accounting of disclosures, you must submit your request in writing to our Medical Records Department. Your request must state a time period which may not go back further than six years. You will not be charged for this accounting, unless you request more than one accounting per year, in which case we may charge you a reasonable cost-based fee for providing the additional accounting(s). We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

Right to a Paper Copy of Notice. You have the right to receive a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. A paper copy of this Notice can be obtained from the receptionist at any APMC site and is also available at our website at www.advancedpaintulsa.com.

Complaints. You have the right to file a complaint if you believe your privacy rights have been violated. If you would like to file a complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: Advanced Pain Management Center, Attention: Privacy Officer, 3840 S 103rd East Ave, Tulsa, OK 74146or by contacting our Privacy Officer at 918-921-9700.

You have the right to complain to the United States Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

CONTACT INFORMATION, QUESTIONS OR CONCERNS If you have questions or concerns about your privacy rights, or the information contained in this Notice, please contact the Advanced Pain Management Center Privacy Officer in writing at 3840 S 103rd East Ave, Tulsa, OK 74146, by phone at 918- 879-1700 or by email at asalguero@apmcok.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I,_____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

Authorized Release of Personal Medical Information

Please list family members/others who may need to speak with any of our staff regarding your medical information such as:

- Billing/Insurance
- Coordination of Care
- Scheduling

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Please list any specific instructions or limitations:

_____

_____

_____

_____

This authorization will remain in effect unless request is received by our office in writing requesting change.

By signing this form, I authorize the release of my personal medical information only to person(s) listed above.

Patient/ Authorized Signature_____Date_____