ADVANCED PAIN MANAGEMENT

New Patient Information

PLEASE FILL OUT IN ITS ENTIRETY

Name: _____ _____ _____
First Middle Last

DOB:_____ SSN: _____-_____-_____ **Gender:** ☐ Female ☐ Male ☐ Transgender

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Cell Phone #: _____ Home Phone #: _____

Work Phone #: _____ Email: _____ Occupation: _____

Emergency Contact: _____ Relation: _____Phone: _____

Ethnicity: ____African American _____Caucasian _____Hispanic _____Asian Other: _____
Primary Language: _____

Primary Care Provider (PCP):_____ **Phone**: _____

Referring Provider: _____ **Phone:** _____

Referral Source: _____

AUTHORIZATION TO RELEASE INFORMATION

Name_____ Relationship to Patient _____

Name_____ Relationship to Patient _____

PRIMARY INSURANCE INFORMATION

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Relationship to Patient: _____

SSN: _____

Insurance Name:_____

Subscriber ID:_____

Group#: _____

SECONDARY INSURANCE INFORMATION

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Relationship to Patient: _____

SSN: _____

Insurance Name:_____

Subscriber ID:_____

Group#: _____

PLEASE FILL OUT IN ITS ENTIRETY

ADVANCED PAIN MANAGEMENT

Today's date: _____

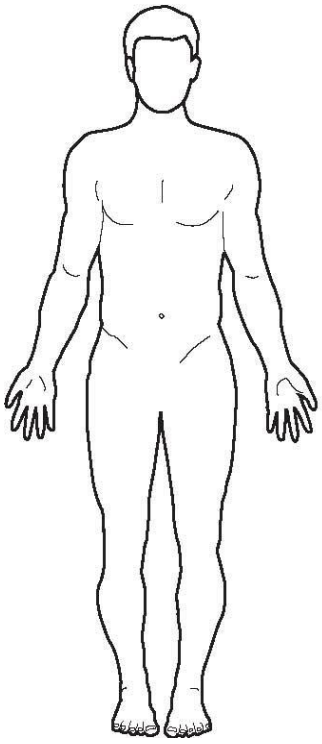
New Patient Intake Form

Full Name: _____ Age: _____ Occupation: _____

1. Chief complaint (pain): _____
2. Onset of symptoms (date/description):_____
3. Are you experiencing radiating pain? (description): _____

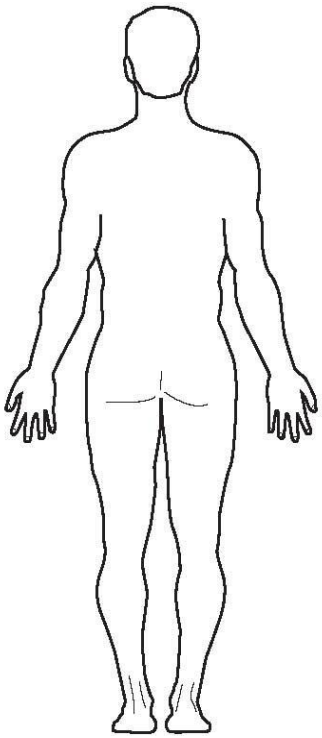
Shade areas of pain or discomfort on the images below:

Front

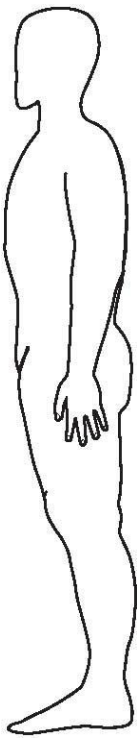


Right Side

Back



Left Side



1. Please rate your pain on a scale of 0-10, with 0 being no pain and 10 being the worst pain imaginable:
   At its best: _____ At its worst:_____ At this moment: _____
2. Select the frequency at which your pain occurs (circle):
   Continuously Several times a day Intermittently Occasionally Less than daily
3. When is your pain worse? Morning Afternoon Evening All the Time No Usual Pattern
4. Describe any changes in pain intensity since its onset: Better Worse No Change

5. Select one or more items below to describe your pain (circle all that apply):
   Aching Burning Cramping Dull Electric Shock Sharp Shooting
   Stabbing Throbbing Deep Numb Tingling Other: _____

6. Please circle the ones your pain interferes with (circle all that apply):
   General Activity Mood Walking Ability Normal Work
   Sleep Enjoyment of Life Intimacy

7. What makes the pain worse? (circle all that apply):
   Standing Sitting Walking Movement Lying down Bending forward
   Arching backward Coughing Sneezing Using the restroom Other: _____

8. What makes the pain better? (circle all that apply):
   Standing Sitting Walking Movement Lying down Coughing Sneezing
   Bending forward Arching backward Using the restroom Other: _____

9. What tests have been done and when? (circle all that apply & give dates and location of imaging):
   X-ray: _____ MRI: _____ CT: _____ EMG: _____ Bone Scan: _____
   Other: _____

10. Do you have any of the following symptoms associated with your pain?
    Numbness/Tingling If yes, where?_____
    Weakness If yes, where? _____
    Bowel/Bladder Incontinence If yes, when did it start? _____

11. List the names of other doctors or specialists you have seen for your pain or who have treated your pain:
    _____
    _____

12. Please check all procedures or modalities you have tried to manage or treat your pain: Did it help?
    Acupuncture_____ Massage _____
    Biofeedback_____ Meditation_____
    Chiropractor_____ Nerve Blocks _____
    Epidural_____ Physical Therapy _____
    Facet Block_____ Psychotherapy_____
    Ice/Heat_____ Surgery_____
    Medications_____ TENS_____
    Other _____

13. Are you involved in any litigation or lawsuit regarding your pain? Yes No

14. Are you seeking Workers' Compensation as a result of your pain? Yes No

15. Medical Illnesses (please circle):

    Arthritis Cancer: _____ Diabetes Headaches Hepatitis Asthma COPD Stroke

    Hypertension Kidney Disease Thyroid Disease Seizure Disorder GERD Other: _____

16. Prior Surgeries (please list type & date):
    _____
    _____

17. Allergies: _____

18. Current Non-Pain Medications (name and current dose):

Do you take any of the following blood thinners? (circle all that apply):

Aspirin Coumadin Plavix Heparin Brilinta Eliquis Xarelto Lovenox

19. Current Pain Medications:

20. Previous Pain Medications:

21. Social History: Single Married Divorced Widowed Legally Separated
Use tobacco? Amount_____ Use alcohol? Amount _____
Use illegal drugs? Type_____ Been treated for alcohol or drug addiction? YES NO

22. Family History (circle all that apply):
Cancer Who?_____ **Diabetes** Who? _____
Heart Disease Who?_____
Stroke Who? _____**Depression/Suicide** Who?_____
Alcohol/Drug Abuse Who? _____

I, the undersigned, have completed this form. The information that I have provided is true and accurate to the best of my knowledge.

X_____ _____Date
Patient/Legal Guardian Signature

X_____ _____
Person signing on patient's Behalf/Relationship Reason patient is unable to sign

Office Policies and Procedures

Appointments, Cancellations, and "No-Shows"

Please try to arrive a few minutes early for your appointment to allow time for sign-in. We understand that unexpected circumstances occur. However, patients who arrive more than 15 minutes late for their appointment are subject to being rescheduled. If you must cancel your appointment for any reason we must be notified 24 hours in advance. This allows for our patients on the waiting list to get the care they deserve. Appointment slots are very important. If we are not given proper notice you will be subject to a **$35 fee** at your next appointment. If your appointment was missed due to an emergency please provide those records in order to waive the "no-show" fee.

Early Appointment Requests

We do our best to accommodate patients needing earlier appointments than allowed. In this instance we will approve only on a case by case basis and request remaining medication be brought in to your appointment to confirm opioid compliance. If you are leaving town we will require flight itinerary for an early refill which will be allowed **only once**.

Getting the most from your visit

As our schedule fills quickly we request you stay in contact with our office regarding any pertinent lab work and radiology reports. Although we will make every effort to contact you regarding your lab or test results, please do not assume that "no news is good news." Occasionally, due to factors beyond our control, results do not get sent to our office or rarely become lost. Thus, it is your responsibility to follow-up on the results of your tests particularly if you have not heard back from us in a timely manner. To ensure efficiency of your time and the time of our staff we appreciate your complete contact information including contact number, insurance changes, and address changes. If we are unable to reach you and your appointment is missed a no-show fee will be charged. Please check with our receptionist to ensure we have a complete and correct chart on file at each appointment.

Opioid Compliance

As a pain management specialist controlled substances may be commonly prescribed. In the instance you have received a controlled substance prescription, please understand we monitor compliance very closely. We do not write for more than thirty days of medication at a time and in turn, will not fill these prescriptions early. **We do not view running out of medication to be an emergency.** You are responsible for taking your medication in the manner in which it was prescribed. If you run out of medication before your next appointment, you may not be issued more medication, unless at the discretion of the physician or nurse practitioner. No refills or medication changes will be given after hours, on weekends or holidays. Narcotics will not be refilled unless you are seen in the office monthly and comply with the pain management therapy program. Please remember that **it is your responsibility** to monitor you medication usage and to plan for your follow-up visit if you need a refill. We suggest you do not wait until you are out of medication to call and check on your appointment slot or make an appointment. We do also collect urine samples on a random basis. Once you have checked in you will not be able to leave the premises without this collection. Please refer to our opioid contract given when we established a new patient relationship for all rules and regulations. **You may be subject to discharge if you do not comply. Please request a copy if you need reference.**

Courtesy to other patients

Many of our patients suffer from respiratory problems, allergies, migraines, etc., as a courtesy to those patients please:

a. Refrain from wearing perfumes or cologne to your office visit
b. Do not smoke before or during your visit
c. If you have a cough or believe you have a contagious illness, please request a mask from the receptionist and wash your hands upon arrival and at departure
d. Refrain from holding loud or disruptive conversations via cell phone in the lobby

Telephone Communication

We are happy to address your questions or concerns via telephone whenever possible. However, treating you by phone without a proper face-to-face evaluation has many potential pitfalls and will be avoided. You certainly wouldn't ask your mechanic to diagnose and treat your car's problem by telephone**. Clearly, your health deserves better treatment.** Please do not ask us to call in medications without an office visit. In addition, most providers are advised not to give "complex information" or discuss "emotionally charged issues" via telephone. Thus, we hope that if someone from our staff calls requesting a return visit to discuss test results, you will understand and not just assume the worst. For those issues that can be resolved via telephone however, we strive to address them by the conclusion of each business day. However, unexpected circumstances do occasionally occur so please allow one business day for answers to telephone inquiries.

FMLA/Disability Form Requests

We may fill out FMLA on a **case by case basis**. There is a fee associated with this of $25. However, **we do not fill out disability form requests**. In the event that you do require disability, you will need to have these forms completed by your primary care physician or appropriate surgeon whom you would be referred to.

Billing/Financial Hardships

We make every effort to explain all insurance plan benefits at the time of establishing a doctor-patient relationship. However, **it is your responsibility** to understand your insurance benefits and costs you may be responsible for. Payment is due at the time of service. Please see our front desk for any additional insurance questions you may have.

I have read and understand the Office Policies and Procedures provided by Advanced Pain Management and have also received a copy for my own records. I hereby authorize APM to prescribe and provide treatment under the circumstances given.

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to the physician or facility named above the following rights, power and authority. During the course of treatment by Advanced Pain Management (APM), charges will be accumulated and routinely filed with your insurance company. Charges not covered by your insurance company, patient co-pays, deductibles and co-insurance **will be your responsibility and are due at the time of service.**

_____ I certify that I have no insurance and will be solely responsible for payment in full. I understand APM has the right to change the fee schedule for private pay at any time deemed necessary.

_____ I certify that the insurance reported to APM is a complete listing. I understand that the office will not extend credit on, or submit a claim for any insurance not reported at the time of service. I also understand that any claim not paid for by my insurance within 60 days from the date filed, will become my responsibility and payable upon billing.

_____ I certify that I have an active workers' comp arrangement in which they have taken full financial responsibility for my treatment process at APM.

Signature of Patient:_____ Date: _____

Print Name: _____

(For Office Staff ONLY)

Witness Signature:_____ Date:_____

Informed Consent and Agreement for Opioid Therapy of Pain

Pain relief is an important goal for your care. Opioid medications may be a helpful part of chronic pain treatment for some people; however, misuse of opioid medications may result in serious harm to patients prescribed them and, when the medications are diverted, to the public at large. As opioid use for pain management has increased in recent years, injury, addiction, and death due to misuse of opioids have also increased.

Potential Risks or Side Effects of Opioid Treatment

Physical Side Effects - May include mood changes, drowsiness, nausea, constipation, urination difficulties, depressed breathing, itching, bone thinning and sexual difficulties such as lowering of male hormone in men and cessation of menstrual periods in women.
Tolerance - A dose of an opioid may become less effective over time even though there is no change in your physical condition. If this happens repeatedly your medication may need to be changed or discontinued.
Addiction - Is more common in people with personal or family history of addiction, but can occur in anyone.
Hyperalgesia - Increased sensitivity to and/or increasing experience of pain caused by the use of opioids may require change or discontinuation of medication.
Overdose - Taking more than the prescribed amount of medication or using with alcohol or other drugs can cause you to stop breathing resulting in coma, brain damage, or even death.

Responsibilities in Opioid Therapy of Chronic Pain

Your responsibilities: In order to maximize the potential benefit of opioid medications and to minimize the potential risks, it is important that you accept the following responsibility. In signing this consent, you

Agree to:

*Use your opioid medications as prescribed for the purpose of relieving pain.
*Keep your medications locked up to avoid intentional or unintentional use or diversion by others.
*Discard all unused medications.
*Be honest with your providers about your medications or other drug use.
*Use no illegal drugs or abuse alcohol while being prescribed opioids.
***Do NOT share, sell, trade or in any way provide your medications to others.**
***Receive opioid medication from this practice only.** If opioids are prescribed unexpectedly by another office (For example: Due to an accident or dental procedure), inform this office within 24 hours.
***Fill your opioid medications at one pharmacy only**. Inform this practice within 24 hours if you must use a pharmacy different from your usual one.
*Have urine tests on a regular basis and as requested by your provider.
*Opioid may be discontinued if illicit drugs are found or medication is not present when it should be.
*Bring your opioid medications to the practice when requested.
*Participate in other pain treatments agreed to with your provider.
*Keep all appointments scheduled for your care.

Medications may be discontinued if your treatment plan is not met, if you experience any negative effects from using them, or if you do not abide by this agreement. If you develop complications of opioid use, such as addiction, we will assist you in finding treatment. Please be aware, however, that our practice cooperates fully with law enforcement, the US Drug Enforcement Agency and other agencies in the investigation of opioid-related crimes including sharing, selling, trading or other potential harmful use of these powerful medications.

Pharmacy Information

While under the care of Advanced Pain Management I understand that I am ***required*** to fill ***ALL*** prescriptions at ***ONE*** pharmacy during the course of my entire treatment plan. The pharmacy I wish to use is:

Name:_____ Intersection: _____Phone:_____

I have reviewed this document and been given the opportunity to have any questions answered. I understand the possible benefits and risks of opioid medications and accept the responsibilities described above.

Printed Name:_____Date: _____

Patient Signature:_____ Office Staff: _____

Financial Policy

During the course of treatment by Advanced Pain Management (APM), charges will be accumulated and routinely filed with the responsible parties reported form of payment. Please read the below categories to understand our policy for each.

Insurance Policy Holders:
Charges not covered by your insurance company such as patient co-pays, deductibles, and co-insurance will be your responsibility and are due at the time of service. If your insurance company requires a "referral" from your primary care physician, you will need to contact PCP for the referral. Treatment provided by this office without the required referral will serve as your consent for treatments not covered by insurance and will be payable at the time of service. Any claim not paid for your insurance within 60 days from the date filed, will become account holder responsibility and payable upon billing. Keep in mind, at times your insurance may not pay for the services discussed with your provider. Your insurance only pays for covered items and services when its rules are met, for example obtaining appropriate referrals from your primary care physician. The fact that your insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. **Note: Our company waives responsibility for unknowingly treating any Medicare policy holding patient if you do not disclose this information before services are rendered.**

Our office will only accept secondary insurance policies that have verified benefits and coverage limit before time of service. In some cases, your responsibility may become due with a refund if payment is received from your secondary carrier.

Letter of Protection and Personal Injury Protection:
You understand you will be charged for all services received by APM and the bill is your responsibility. You have authorized an attorney to protect all medical debt accumulated with any settlement received. You will also sign a release of payment directly to provider if your carrier opts to mail payment to patient first. If for any reason, attorney representation is discontinued the account holder becomes immediately responsible for all charges incurred.

Private Pay:
Patients in hardship choosing to pay out of pocket may be offered fair rates to receive as much affordable care as possible. Payment is due in full at time of services.

Payment Plans:
Contact your receptionist to learn more about services that allow payment plan set up.

Consent to Treatment

I have the right to refuse any procedure or treatment. I have the right to discuss all medical treatments with my provider.

Authorization to Release Medical Information

I hereby authorize Advanced Pain Management to provide medical records as requested by my verbally or electronically reported carrier for any charges of services covered by the terms of my policy. I agree to cooperate, aid and assist the facility on procuring all possible insurance benefits including initiation and fulfillment of all policy provisions such insurance companies may require for payment.

I have carefully read and understand to all of the above information which includes APM's Financial Policy, Consent to Treatment, and Medical Release. I hereby authorize Advanced Pain Management to prescribe and provide treatment under all the above terms and conditions.

Signature of Patient or Legal Guardian: _____

Patient Name: _____ Date: _____

Please initial and sign the following statements.

ASSIGNMENT OF BENEFITS:

I authorize payment to Advanced Pain Management, PLLC, for the professional services rendered

Initial: _____

INSURANCE COVERAGE WAIVER:

I wish to receive medical services for Advanced Pain Management, PLLC,. If my insurance did not cover all or part of the charges, I will be financially responsible for payment for the services I received.

Initial: _____

RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process this claim.

Initial: _____

MEDICAL RECORDS RELEASE:

I hereby authorize the release of all hospital records, clinic records, and laboratory and radiology reports to Advanced Pain Management, PLLC, as necessary for medical care.

Initial:_____

NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have received a copy of Advanced Pain Management, PLLC, notice of privacy practices.

Initial: _____

Signature: _____ Date:_____

Disclosure of Physician Ownership and Financial Interest

State and Federal guidelines may require that physicians who may have an affiliation or ownership interest in or with the in and out of network facilities/services to which the physician prefers we must disclose this information. In the interest of providing our patients with complete information, we are providing the names of the out of network facilities where Advanced Pain Management may have an ownership interest/affiliation.

Alliance Anesthesia Services
220 E. Medical Center Blvd. Webster, TX 77598
841 Yale St. Houston, TX 77007

During your course of treatment at Advanced Pain Management, you may be referred to one of these facilities for medical services. These out of network facilities or provider may bill the patient for services not covered by your benefit plan. You have the right to choose the facility where you receive medical treatment/services, including the right to choose a facility/service other than the ones listed above.

By signing below, I acknowledge receipt of the above disclosure information and have a right to a copy of this form.

_____ _____

Patient Signature Date Office Staff Signature Date

HIPAA Privacy Policy

Your privacy is important to us.

Advanced Pain Management and its affiliated entities use health information about you for treatment, to obtain payment for treatment, to evaluate the quality of care you receive, and for other administrative and operational purposes. Your health information is contained in a medical record that is the physical property and responsibility of Advanced Pain Management. Advanced Pain Management is required by law to maintain the privacy of health information about you and provide you with this notice of our legal duties and privacy practices with respect to your health information ("Notice of Privacy Practices" or "Notice"). We must abide by the terms of this Notice currently in effect. Advanced Pain Management reserves the right to change the terms of this Notice, our privacy practices, and to make the new provisions effective for all protected health information we maintain. You may contact Advanced Pain Management's office manager or physician below to obtain a revised Notice of Privacy Practices.

Your Health Information Rights: You have the following rights with respect to health information about you.

Right to Copy of Notice of Privacy Practices. You have the right to a copy of our Notice at any time.
Right to Inspect and Copy. You have the right to inspect and/or obtain a copy of the health information about you that we maintain. Your request must be in writing. We will charge you a fee to cover the costs of copying and mailing that are necessary to fulfill your request. In very limited circumstances, we may deny your request. If we deny your request, we will explain our reasons in writing. Under certain circumstances, you have the right to request that another person at Advanced Pain Management review the decision. We will comply with the review outcome.
Right to Amend. If you feel that health information about you that we maintain is inaccurate or incomplete, you have the right to request that we amend the information. You may request an amendment as long as we maintain the information. We may ask that you submit it in writing and include a reason supporting the request. In certain circumstances, we may deny your request. If your request is denied, we will explain our reasons in writing. You may submit a statement explaining why you disagree with our decision to deny your amendment request. We will share your statement when we disclose health information about you that we maintain in certain groups of records.
Right to an Accounting of Disclosures. You have the right to request an accounting or detailed listing of certain disclosures of health information about you. The time period covered by the accounting is limited to six years prior to the date of your request. Your request must be in writing. If you request an accounting more often than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.
Right to Request Restrictions. You have the right to request a restriction or limitation on the health information about you that we use or disclose. Your request must be in writing. We are not required to agree to your request. However, we must agree not to disclose health information about you to your health plan if the disclosure is for payment or health care operations and relates to a health care item or service which you paid for in full out of pocket. If we agree to your request, we will comply with it unless the information is needed for emergency treatment. We will notify you if we are unable to agree to a requested restriction.
Right to Revoke Authorization. You have the right to revoke your authorization to use or disclose health information, except to the extent that action has been taken in reliance upon your authorization. Your request must be in writing
Right to Request Alternative Method of Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. Your request must be in writing. We will accommodate all reasonable requests.
Right to Notification of Breach. You have a right to be notified if you are affected by a breach of unsecured health information about you.
Right to Opt Out of Fundraising Communications. We may contact you for fundraising purposes. You have the right to opt out to receiving these communications.
Complaints: If you believe your privacy rights have been violated, you may complain to Advanced Pain Management and to the Secretary of the Department of Health and Human Services. You may make a complaint to us by contacting Advanced Pain Management at the address or phone listed below. You will not be retaliated against for filing a complaint.
Uses or Disclosures of Your Health Information That May Be Made Without Your Authorization
Treatment. We may use and disclose health information about you to provide you with pharmacy care or other medical treatment or services. For example, information related to your treatment may be communicated with and obtained by a health care provider, such as a pharmacist, nurse, or other person providing health services to you, and will be recorded in your medical record. This information is necessary for health care providers to determine what treatment you should receive.
Payment. We may disclose health information about you for payment related purposes. For example, we may contact your insurer, payer, or other entity, for purposes of receiving payment for treatment and services that you receive or to determine whether the entity will pay for the particular product or service. The billing information may identify you, your diagnosis, and treatment or supplies used in the course of your treatment.
Health Care Operations. We may use and disclose health information about you for administrative and operational purposes. For example, members of the risk management or quality improvement teams may use health information about you to assess the care and outcomes in your case and others like it. The results will be used internally to continually improve the quality of care for all patients.
Organized Health Care Arrangement. An organized health care arrangement is a clinically integrated care setting in which individuals typically receive health care from more than one health care provider. We may participate in organized health care arrangements with long-term care facilities, hospice, or other health care facilities in connection with the services we furnish to patients in such settings. Health information may be shared between the participants in the organized health care arrangement for the health care operations of the arrangement.
Individuals Involved in Your Care or Payment for Your Care. We may disclose to a family member, other relative, close personal friend or any other person you identify, health information about you directly relevant to that person's involvement in your care or payment related to your care. In addition, we may disclose health information about you to a public or private entity assisting in a disaster relief effort (such as the Red Cross) so that your family can be notified about your condition, status, and location
Business Associates. We provide some services through contracts with business associates, such as accountants, consultants, and attorneys so that they can perform the tasks that we have assigned to them. To protect your health information, we require the business associate to appropriately safeguard health information about you.
Appointment Reminders. We may use health information about you to provide you with appointment or prescription reminders.
Alternative Treatments. We may use health information about you to provide you with information about alternative treatments or other health-related benefits and services that may be of interest to you.
Future Communications. We may communicate with you via newsletters, mailings, or other means regarding treatment options, health-related information, disease-management programs, wellness programs, or other community-based initiatives or activities in which we are participating.

Required by Law. We may use and disclose health information about you as required by federal, state, or local law. For example, we may disclose health information for the following purposes: (1) for judicial or administrative proceedings pursuant to legal authority; (2) to report information related to victims of abuse, neglect, or domestic violence; and (3) to assist law enforcement officials in their law enforcement duties.
Public Health. We may use or disclose health information about you for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.
Health Care Oversight. We may use or disclose health information about you to a health oversight agency for oversight activities authorized by law, such as audits, investigations, and inspections.

Research. We may use or disclose health information about you to researchers if an institutional review board or privacy board has reviewed and approved the research proposal, and established protocols to ensure the privacy of your health information.

Health and Safety. We may use or disclose health information about you to avert a serious threat to your health or safety or any other person pursuant to applicable law.

Medical Examiners and Others. We may use or disclose health information about you to medical examiners, coroners, or funeral directors to allow them to perform their lawful duties. If you are an organ or tissue donor, we may disclose health information about you to organizations that help with organ, eye, and tissue donation and transplantation.

Food and Drug Administration (FDA). We may use or disclose health information for purposes of notifying the FDA of adverse events with respect to food, supplements, product, and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacements.

Information Not Personally Identifiable. We may use or disclose health information about you in ways that do not personally identify you or reveal who you are.

Government Functions. We may use or disclose health information about you for specialized government functions, such as protection of public officials, national security and intelligence activities, or reporting to various branches of the armed services.

Workers Compensation. We may use or disclose health information about you to comply with laws and regulations related to workers compensation.

Correctional Institutions. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may use or disclosure health information about you. Such health information will be disclosed to the correctional institution or law enforcement official when necessary for the institution to provide you with health care and to protect the health and safety of others.

Affiliated Covered Entity. We are part of an affiliated covered entity with other entities that are under common ownership or control. The entity treats itself as a single entity for purposes of using and disclosing health information about you.

Uses or Disclosures of Your Health Information Based Upon Your Written Authorization

Psychotherapy Notes. We must obtain your written authorization for must uses and disclosures of psychotherapy notes.

Marketing. We must obtain your written authorization to use and disclose health information about you for most marketing purposes.

Sale of Your Health Information. We must obtain your written authorization for any disclosure of health information about you which constitutes a sale of such health information.

Other Uses. Other uses and disclosures of health information about you, not described above, will be made only with your written authorization. You may revoke your authorization, at any time, in writing, except to the extent that we have taken action in reliance on the authorization.

Other Applicable Laws
This Notice is provided to you as a requirement of the Health Insurance Portability and Accountability Act ("HIPAA"). There are other laws that may apply and limit our ability to use and disclose health information about you beyond what we are allowed to do under HIPAA.

State Laws. We will comply with your state's laws if they provide you with greater rights over your health information or provide for more restrictions on the use or disclosure of your health information.

Confidentiality of Alcohol and Drug Abuse Patient Records. The confidentiality of alcohol and drug abuse patient records by us is protected by Federal law and regulations. Generally, we may not say to a person outside our alcohol and drug treatment program that you attend the program, or disclose any information identifying you as an alcohol or drug abuser, unless:

(1) You consent in writing;
(2) The disclosure is allowed by a court order; or
(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by the program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal Regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities. For more information, see 42
U.S.C 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 C.F.R Part 2 for Federal regulations.

Contact Information: If you have any questions, requests, or concerns about your Advanced Pain Management-related health information rights or our use and disclosure of health information, please contact: Advanced Pain Management, 220 E. Medical Center Blvd., Webster, TX 77598.
Phone: (832) 930-9001.

Patient Signature:_____ Office Staff Signature: _____