CHRONIC PAIN TREATMENT CENTERS

915 Toll House Avenue, Suite 103 Frederick, MD 21701
(O): 301.624.5390 (F): 301-624-5393

Today's date:	Provider:

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div. / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ()

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: (

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑_____ ❑_____ ❑_____

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] LLC insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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MEDICAL RECORD RELEASE

PATIENT INFORMATION (PLEASE PRINT)

Patient Name:_____

Date of Birth:_____

Address: _____ Telephone #:_____

RELEASE INFORMATION *TO & FROM*:

- Pharmacy Name _____ Contact: _____
- Primary Doctor: _____ Contact: _____
- Previous Pain Mgmt. Provider: _____ Contact: _____
- Specialist: _____ Contact: _____
- Lawyer: _____ Contact: _____
- Lab/Radiology: Millennium Labs Contact: _____
- Other, Specify: _____ Contact: _____

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY)

☐ Clinic Visit Notes	☐ Imaging Reports	☐ Pathology Reports
☐ Complete Chart	☐ Lab Reports	☐ Pharmacy Reports
☐ Discharge Summary	☐ Operative Reports	☐ Other: _____

Patient Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF SENSITIVE INFORMATION

This medical record may contain certain sensitive or statutorily protected information. Please indicate the information you would like released. A separate signature is required.

☐ Mental Health Information	☐ Social Service Information
☐ Domestic Violence Information	☐ Sexual Assault Information
☐ Alcohol/Drug Abuse Information	☐ Sexually Transmitted Diseases

Patient Signature: _____ Date: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Chronic Pain Treatment Centers, LLC

I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information. I certify that I have received a copy of this authorization.

_____ _____

Patient Signature/ Guardian Date Witness Date

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MEDICAL HISTORY

CHECK THE BOX IF YOU HAVE HAD ANY OF THE FOLLOWING:

	Diabetes		Rheumatic Fever		Heart Murmur
	High Blood Pressure		Migraines/ Headaches		Osteoporosis
	Circulatory Problems		Lung Disease		Epilepsy/ Seizures
	Arthritis		Neurological Problems		Cancer
	Stroke		Heart Disease/ Pacemaker		Fractures
	Kidney Disease		Liver Disease		Metal Implants

Other: Please explain_____

List any significant hospitalizations and surgical procedures/ reasons/ dates:

_____

_____

_____

_____

List any medications that you are presently on:

_____

Do you have any medication allergies?

_____

Is there a chance you may be pregnant at this time? Yes_____ No_____

PLEASE BRIEFLY PROVIDE A HISTORY OF YOUR CHRONIC PAIN.

_____

_____

_____

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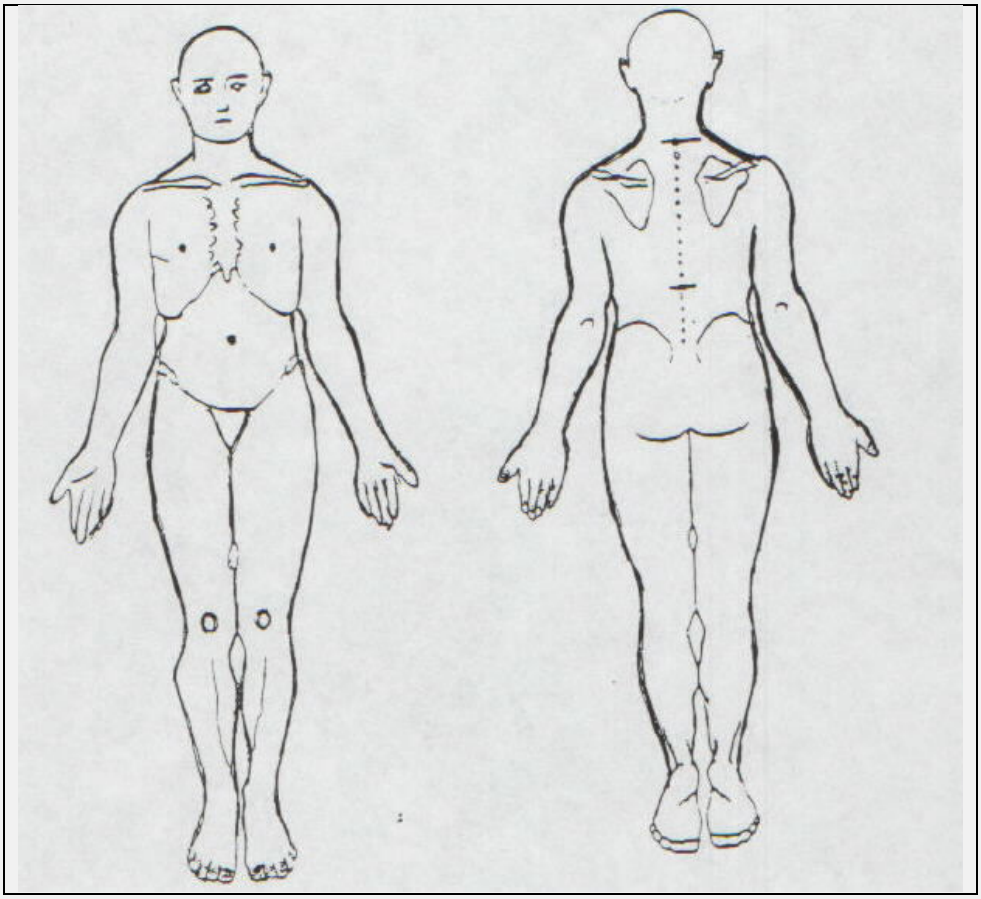
Is the pain constant/ intermittent? _____

Rate the pain intensity on a scale of 0-10 (10 being the worst pain)

0 1 2 3 4 5 6 7 8 9 10

On the drawings, please circle where you are experiencing pain. Please make note inside the circle using the chart below to tell us what type of pain you have.



Numbness =N

Tingling=T

Dull Pain = D

Sharp Pain =P

Burning =B

Stiffness = S

Does the pain radiate? Yes_____ No_____ Where? _____

How would you describe the pain: _____

What makes it feel better? _____

What makes it feel worse? _____

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Patient Data

My Primary Care provider is: _____

My Specialist provider is: _____

My Primary Pharmacy is: _____

My Previous Pain Management Provider is: _____

My Primary Insurance coverage is: _____

Financial Agreement

Thank you for choosing our office for your pain management needs. Please read the following information and sign below.

Insurance-In Network Carriers: CPTC will submit insurance claims for in network insurance carriers only. Patients will be responsible for all Deductibles and Copayments at the time of service. Patients will be liable for any balance that is not collected from the third party payer. Our office will attempt to appeal a denied claim, 1 time, if possible.
Insurance- Out of Network: Patients may request a receipt to submit to out of network providers. Payment is due at the time the service is rendered.
Private-Pay: Patients must pay, in full, at the time of service.
Payment Options: Debit or Credit Cards (Visa, MasterCard, and Discover) Flex Spending or Cash. NO Checks will be accepted. Credit Card must be issued in the patient name.

I have read the information above and acknowledge my understanding of the policy concerning financial matters.

_____ _____
Patient/Responsible Party's Signature) Date

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DRUG TEST AUTHORIZATION PERMISSION FORM

I, _____, acknowledge that I have been advised that I may be required to submit to an observed urine drug screen test as part of the Treatment policy of CHRONIC PAIN TREATMENT CENTERS, such drug tests are a requirement of our patient practices. I further understand that CPTC policy address the presence of illicit substances and or non- prescribed opioids in the systems of our patients. A confirmed positive test is a violation of this policy. Additionally, a refusal to test, failure to submit adequate urine for test, or adulterated sample, constitutes a positive test and may result in probation or discharge.

I further understand that this analysis will be conducted by a certified laboratory with all data to be held in confidence except as otherwise necessary to carry out the terms and objectives of this policy.

I understand that it is my responsibility prior to the drug testing to inform the laboratory and/or Staff of any medication, prescribed or non-prescribed, that I may be taking and/or have taken within the last 60 days prior to the testing.

I understand that the laboratory is a third party provider. Charges and payments are due directly to the third party provider. CPTC will supply demographics and insurance information to the lab provider for billing purposes with permission per signing this form.

I consent to the release of the results of any drug test to authorized representatives of the CPTC medical practice for appropriate review.

I consent freely and voluntarily to a drug test under the circumstances described above along with all the terms and conditions of the Patient Treatment Policy. I also understand that although I may not agree with the Drug Screening Consent, failure to acknowledge the policy with my signature below may prohibit my treatment with CPTC and can result with an immediate discharge from the practice. A photocopy of this authorization shall be deemed an original and shall be accepted as such by every person.

_____ _____
Patient's Full Printed Name Date

_____ _____
Patient's Signature Date

_____ _____
Provider Signature Date

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PATIENT & PROVIDER AGREEMENT

PLEASE READ EACH SECTION CAREFULLY INITIAL EACH PROVISION ONCE YOU HAVE READ, FULLY UNDERSTAND, and AGREE TO ABIDE BY THE STATEMENT

This is an agreement between _____ (herein referred to as "PATIENT") and CHRONIC PAIN TREATMENT CENTERS, LLC (Herein referred to as "CPTC") and/or any of its currently employed Physicians and /or Practitioners (Physician Assistants, Nurse Practitioners, etc.) concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of chronic pain problem(s). Any medication potentially prescribed will probably not completely eliminate your pain, but it is expected to reduce it enough that you may become more functional and improve your quality of life. The purpose of this agreement is to protect your access to potentially prescribed controlled substances and to protect our ability to prescribe to you, in addition to limiting the overall liability of CPTC and the members of its clinical staff (front office staff, back office staff, the physicians, and members of the clinical staff, such as, but not limited to, PAs, NPs).

Opioid medications have potential for abuse or diversion, strict accountability is necessary with patients enrolled monthly treatment plans. For this reason the following policies are agreed to by you, the Patient, in consideration for, and as a condition of willingness of the medical staff provider whose signature appears below, to consider the initial medical evaluation and/or the continued prescribing of controlled substances to treat your chronic pain.

By reviewing and initialing each section below, you hereby indicate that you have read and understand each section of the "Patient and Provider Agreement." In addition, you, PATIENT, agree to release the medical clinical staff of CPTC, up to, but not including CPTC's Physicians, Physician Assistants, Nurse Practitioners, CPTC's front office staff, CPTC's back office staff and CPTC management and ownership entities, of any liability that may result in violating any one of the below mentioned sections that you agree to adhere to.

_____1. I understand that controlled medications (opioid & non opioid) could cause physical dependence and/or tolerance can occur with the use of opioid medications.

_____ 2. I understand that controlled medications (opioid & non opioid) present a high risk for addiction and that addiction could occur. If this occurs, the controlled medication (opioid & non opioid) will be discontinued and I will be referred to a drug treatment program for help with this problem.

> Physical dependence means that if the opioid medication is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal physiological response. The withdrawal syndrome could include, but not exclusively, sweating, nervousness, abdominal cramps, diarrhea, goose bumps and alterations in one's mood.
>
> It should be noted that the 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.
>
> 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.
>
> Tolerance means a state of adaption in which exposure to the drug induces changes that result in diminution 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.

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_____3. (Females Only) I understand that if I am pregnant or become pregnant while taking these controlled medications (opioid & non opioid), I will notify the CPTC medical staff, accordingly. I understand that I may be asked to provide a random urine or blood sample for pregnancy testing, this is to document that I am not pregnant. Failure to provide a sample, upon request, may require CPTC to take action including but, not limited to, postponement of my next appointment, discontinuation of treatment, and/or discharge from the practice.

_____4. Overdose of controlled medication (opioid & non opioid) may cause death by (including, but not limited to) respiratory depression (slowing/stopping breathing); this can be reversed and/or treated by emergency personnel if they know I have taken controlled medication (opioid & non opioid). It is recommended that I wear a medical alert bracelet or necklace that contains information on my controlled medication (opioid & non opioid). Controlled medications (opioid & non opioid) may be hazardous or lethal to a person who is unfamiliar to their effects, especially a child. Controlled medications (opioid & non opioid) must be kept out of reach of children.

_____5. Some of the medications (opioid & non opioid) cause drowsiness, sedation, or dizziness. In addition, I am stating that I understand the physical qualities of drowsiness, sedation, and/or dizziness, as they relate to me personally and I agree that I must not drive a motor vehicle or operate heavy machinery, should that happen.

_____6. I understand that it is my responsibility to inform BOTH the CPTC clinical staff and medical staff of any and all side effects or adverse effects experienced from the medications (opioid & non opioid) prescribed.

_____7. I agree to inform the CPTC clinical staff of any new medications (opioid & non opioid) and/or additional medications (opioid & non opioid) I have taken since my last visit and any new medical conditions or symptoms I am experiencing since my last visit.

_____8. I understand that prescriptions will be filled only during scheduled office visits with the treatment team. If my medication is not working, or I have a reaction I will call my provider to schedule an appointment.

_____9. I agree to take all medications (opioid & non opioid) as prescribed for me and not to change the amount or frequency of the medication (opioid & non opioid) without discussing it with the prescribing CPTC medical provider. CPTC reserves the right to take action including, but not limited to, postponement of future appointments, discontinuation of treatment, and/or discharge any patient from its practice if it is determined that the patient has abused or misused any of the medications (opioid & non opioid) prescribed by an CPTC provider. Clear indication of misuse of prescribed medications (opioid & non opioid) include, but are not limited to, running out of prescribed medications early, escalating doses without permission, and/or losing prescriptions.

_____10. I agree that if at any time I request to change my appointment date to an earlier date, I must bring in documentation and all of my medication. Repeat request for early appointments will not be granted.

_____11. I agree that all controlled medications (opioid & non opioid) will come from the CPTC physician or medical provider whose signature appears below or during his/her absence, by the covering provider, unless specific authorization is obtained. I agree NOT to take any additional pain medication prescribed by any other physician without first discussing it with a CPTC medical provider. I give permission for the CPTC clinical staff to verify I am not under the care of any other physician for pain management, and that I do not have any other prescriptions for controlled medications (opioid & non opioid), other than those prescribed by CPTC providers. In addition, I give

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CPTC clinical staff the permission to verify I am not receiving my controlled medication (opioid & non opioid) from multiple pharmacies which CPTC has not been made aware of. This permission allows providers and approved staff to verify patient prescription history through the use of CRISP, when necessary. In the situation where CPTC becomes aware of any violations of the policy, CPTC reserves the right to take action including but, not limited to, postponement of my next appointment, discontinuation of treatment, and/or discharge from the practice.

_____12. I agree to keep my controlled medication (opioid & non opioid) in a lockbox and in a secure location. Lost, stolen, or damaged medication WILL NOT be replaced. I understand that absolutely NO exceptions can be made by my provider. All incidents will be evaluated by the Medical Director AND Director of Operations to determine a plan of action.

_____13. I agree NOT to sell, lend, or in any way give my controlled medication (opioid & non opioid) to any other person. If I am caught selling, lending or giving away medication I will be discharged WITHOUT MEDICATION.

_____14. I agree NOT to drink alcohol or take mood altering drugs while I am taking controlled medications (opioid & non opioid). Should I violate the alcohol policy of CPTC while taking any of my prescriptions and/or controlled medications (opioid & non opioid), I agree to hold harmless AND release from any and all legal liability, all members of the CPTC clinical staff and management staff (including, but not limited to office management and owners, medical providers, and/or partners).

_____15. I will not get any opioid pain medicines or other medications that can be addictive such as benzodiazepines (Klonopin, Xanax, Valium) or stimulants (Ritalin, Amphetamine) without telling a member of the treatment team before I fill that prescription. I understand that the only exception to this is if I need pain medicine for an emergency outside of CPTC business hours.

_____16. I agree not to discuss my medications or involve myself in illegal activity on CPTC property which could result in discharge.

_____17. I agree that I will attend all required follow up appointments with the CPTC clinical staff to monitor my controlled medication (opioid & non opioid). I understand that failure to do so may result in, but is not limited to, postponement of my next appointment or discharge from the practice. I also agree that I will make every possible effort to participate in other chronic treatment modalities recommended by the CPTC clinical staff.

_____18. I understand that at any given time I may be called in for a medication count. This means I must present to CPTC with my medication in the original pharmacy container within the time allotted by staff.

_____19. I understand that I must provide CPTC with an active contact number at all times. If at any time staff cannot reach me at the numbers I have provided, I will be subject to probation or discharge.

_____20. I understand that if anytime my drug screen test positive for illicit substances I may be discharged, my medication may be reduced and/or my treatment team will evaluate probation requiring A&D evaluation.

_____21. I understand that if at any time my drug screen tests negative for my medication I will be evaluated by my treatment team for discharge when lab confirmation is received. I may or may not receive medication during this evaluation based on my treatment team's decision.

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_____22. I understand the discharge guidelines below and understand that it is at the sole discretion of the CPTC medical provider if they choose to discharge or enroll me in the 3-month probation program. While on probation I will pay $120.00 per monitoring visit required by my provider. I may be discharged:

- If I do not tell my provider or a medical staff member that I am being prescribed opioid pain medication or any other controlled medication (opioid & non opioid) from another physician, practitioner, or dentist.
- I obtain opioid pain medication or other controlled medication (opioid & non opioid) by misrepresentation, fraud, forgery, deception, or subterfuge.
- For falsification of a urine sample or urinalysis/lab test failure. Testing failure includes, but is not limited to, the presence of legal or illegal substances (opioid & non opioid) in the urinalysis and/or serum toxicology testing. CPTC specifically excludes positive urinalysis of marijuana as a violation of the patient contract and reserves the right to continue treating patients with such results.
- For failure to comply with scheduled medication counts and/or failure to adequately account for medications (opioid & non opioid) prescribed.
- For failure to provide an active contact number.
- Inappropriate and/or unprofessional behavior towards any member of the CPTC staff.

_____23. I will sign a release form to allow the providers to speak with all other doctors or providers that I see.

_____24. Should it be determined that I have been involved in diversion (selling, lending or giving away) of the medication prescribed by FSRC, I understand that local law enforcement may be notified, per guidelines.

_____25. I have received a copy of the Notice of Privacy Practices and the HIPAA guidelines.

I have read the above agreement, have asked any and all necessary questions, and understand each section that I have initialed. I acknowledge that I have been explained the risks and potential benefits of these therapies. Therefore, I understand that failure to adhere to these policies may, in the sole discretion of CPTC, result in the postponement of my next appointment, discontinuation of treatment, placement on probation, and/or discharge from the practice. I affirm that I have full right and power to sign and be bound by this agreement and accept all of its terms.

_____ _____ _____

Patient's Name Printed Patient Signature Date

_____ _____

Provider Signature Date