EASTERN SHORE PAIN MANAGEMENT, P.C.
PO Box 2064
Fairhope, AL 36533

REGISTRATION AND HISTORY

PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____
City State Zip

Sex: ❑ M ❑ F Age _____ Birthdate _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Method of payment - ❑ Cash ❑ Check ❑ Insurance ❑ Debit Card ❑ MasterCard ❑ Visa

Insurance Co. _____

Group # _____

Is Patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____, and assign directly to Dr. Robert E. McAlister, Jr., M.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Dr. McAlister is a Medicare opt out Physician and does not render services which may have been or are covered under Medicare except for emergency or urgent care services.

_____
Responsible Party Signature

_____ _____
Relationship Date

PHONE NUMBERS

Home _____ Work _____ Cell _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT _____

Name _____ Relationship _____

Home Phone _____ Work Phone _____

ACCIDENT INFORMATION

Is condition due to an accident? ❑ Yes ❑ No Date _____

Type of accident ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?

❑ Auto Insurance ❑ Employer ❑ Worker Comp. ❑ Other

❑ Legal action pending

Attorney Name (if applicable) _____

PLEASE READ AND SIGN:

I, THE UNDERSIGNED, HEREBY AGREE TO PAY ALL AMOUNTS AND CHARGES HEREAFTER INCURRED BY MYSELF AND OTHER MEMBERS OF MY FAMILY FOR SERVICES RENDERED. FAILURE TO MAKE PAYMENT WHEN REQUESTED IS A BASIS FOR LEGAL ACTION AND THE UNDERSIGNED AGREES TO PAY ALL COSTS OF COLLECTION INCLUDING A REASONABLE ATTORNEY'S FEE. I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE, AND THAT I, AND NOT MY INSURANCE COMPANY, AM RESPONSIBLE FOR THE ENTIRE BILL.

I HEREBY ACKNOWLEDGE RECEIPT OF YOUR PRACTICE'S PRIVACY NOTICE AND UNDERSTAND YOUR PRIVACY POLICY POSTED IN YOUR PATIENT WAITING ROOM.

I AUTHORIZE ROBERT E. McALISTER, JR., M.D., TO RENDER MEDICAL TREATMENT DEEMED NECESSARY BY HIM TO THE PATIENT NAMED HEREIN.

DATE _____ SIGNATURE _____ (SEALED)

DATE _____ WITNESS _____ (SEALED)

Patient Condition

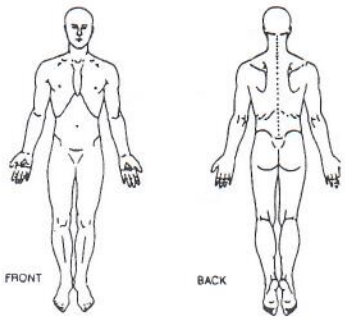
Are you pregnant? ❑ Yes ❑ No If no, LMP _____

Reason for Visit _____

When did you symptoms appear? _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Unknown

Mark an X on the picture where you continue to have pain, numbness or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching

❑ Shooting ❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

How often do you have this pain? _____

Is it consistent or does it come and go? _____

Does it interfere with your ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that are painful to perform ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

Health History

What treatment have you already received for your condition? ❑ Medications ❑ Surgery ❑ Physical Therapy

❑ Chiropractor ❑ Acupuncture ❑ None ❑ Other _____

Name and address of other doctor(s) who have treated your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Please check ☑ conditions or symptoms you currently have or have had in the past:

❑ AIDS/HIV	❑ Cataracts	❑ Herniated Disk	❑ Parkinson's Disease	❑ Tuberculosis
❑ Anemia	❑ Chemical Dependence	❑ Herpes	❑ Pinched Nerve	❑ Tumors, Growth
❑ Anorexia	❑ Diabetes	❑ High Blood Pressure	❑ Pneumonia	❑ Ulcers
❑ Appendicitis	❑ Emphysema	❑ High Cholesterol	❑ Polio	❑ Varicose Veins
❑ Arthritis	❑ Epilepsy	❑ Jaw Pain/TMJ	❑ Prosthesis	❑ Whiplash
❑ Asthma	❑ Glaucoma	❑ Kidney Disease	❑ Psychiatric Care	Other _____
❑ Blood Clots	❑ Goiter	❑ Liver Disease	❑ Rheumatoid Arthritis	_____
❑ Breast Lump	❑ Gout	❑ Mononucleosis	❑ Rheumatic Fever	_____
❑ Bronchitis	❑ Heart Disease	❑ Multiple Sclerosis	❑ Scarlet Fever	_____
❑ Bulimia	❑ Hepatitis	❑ Osteoporosis	❑ Stroke	_____
❑ Cancer	❑ Hernia	❑ Pacemaker	❑ Thyroid Problems	_____

EXERCISE		WORK ACTIVITY		LIFESTYLE	
❑ None	❑ Daily	❑ Sitting	❑ Light Labor	❑ Smoking Packs/Day _____	❑ Coffee/Caffeine Cups/Day _____
❑ Moderate	❑ Heavy	❑ Standing	❑ Heavy Labor	❑ Alcohol Drinks/Week _____	❑ High Stress Level Reason _____

Medications

_____

_____

_____

_____

Allergies

_____

_____

_____

_____

Vitamins/Herbs/Minerals

_____

_____

_____

_____

Medical Information Authorization

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

I authorize the personnel of Eastern Shore Pain Management to release all medical information to my family members and friends listed below.

I may revoke this authorization by phone or in writing at any time.

Name: _____
Relationship: _____
Phone Number: _____

Name: _____
Relationship: _____
Phone Number: _____

Name: _____
Relationship: _____
Phone Number: _____

Permission to leave a message on an answering machine or voicemail ☐ Yes ☐ No

_____ ____/ ____/ ____
Patient Signature Date

_____ ____/ ____/ ____
Witness Signature Date

Eastern Shore Pain Management
& Family Medicine Center

Robert E. McAlister, Jr., M.D.
Office: (251) 929-2050
Fax: (251) 929-2070

23710 U.S. Highway 98, Suite B
P.O. Box 2064
Fairhope, AL 36533

We welcome you to Eastern Shore Pain Management. It is important to ESPM that our patients are first priority and are cared for in the most professional and comfortable way. In order for this to be achieved, we have some policies that are vital to the excellent service we offer.

1. No family member is allowed in the room with a patient until after the patient has been seen by the doctor. This enables the patient/doctor relationship to remain confidential. However, after the doctor has seen the patient, members of the family may need to ask questions, and are welcome to do so at that time. We do ask that small children not be included in the room at any time, as this has caused distractions and time away from the care of the patient.

2. No prescription under any circumstances will be called in for a patient. It is the patient's responsibility to monitor his own medication and keep it in a safe place. No medication will be refilled earlier than 3 days before the refill date, even if an appointment is made to see the doctor prior to the refill date.

3. Out of courtesy for the doctor, as well as our dependable patients, we ask that you call the office if you are going to be more than 15 minutes LATE and/or NOT BE ABLE TO MAKE YOUR APPOINTMENT AT ALL. If a pattern of not calling to inform us of your status with your appointment occurs more than 2 times, all your appointments thereafter will be considered as "walk-ins" and be treated in that manner.

4. All implemented treatment plans for patients should be followed, allowing favorable results in their treatment. Treatment plans may vary, consist of bi-weekly appointments, weekly appointments, or what is deemed to be in the best interest of the patient. We will not refill any medications for those who do not follow their personalized treatment plan.

Thank you for assisting Eastern Shore Pain Management in providing the best possible medical care to our clients. We are pleased that you have chosen our office to assist you with your medical needs. We feel that with your cooperation in the policies listed above, we have an opportunity to achieve our medical goals. We value you as a patient, and our hope is to see you "pain free."

Please read and sign below, indicating that you have **read and understand** the above policies.

_____/_____ _____/_____
Patient Name Date Witness Date

Patient Name _____ Chart # _____ Date: _____

EASTERN SHORE PAIN MANAGEMENT, P.C.
PO Box 2064
Fairhope, AL 36533

PRESCRIPTION MEDICATION CONTRACT

The Eastern Shore Pain Management staff and myself have a common treatment goal: to improve my ability to function and/or work. In consideration of that goal, I may be treated with some potent medications, some of which are narcotics or tranquilizers. These medications are controlled substances and, therefore, monitored by local, state and federal agencies. These medications are highly effective when taken as directed under medical supervision, but they also have potential for misuse and abuse.

I THEREFORE AGREE TO ABIDE BY THE FOLLOWING CONDITIONS:

- I agree that all medications for the control of the pain related to my pain condition shall be prescribed **only** by my pain management physician. I agree to inform my pain management physician immediately if I obtain a prescription for pain control from any other source for any reason.
  _____(initial)

- If my referring physician or primary care physician prefers to write prescriptions for all my medications, including those prescribed for pain, I will inform my pain management physician of this, and he will then only make recommendations to my primary care physician.
  _____(initial)

The following agreements pertain only to medications prescribed by the Pain Management physician at Eastern Shore Pain Management:

- I understand that certain medications may interact with others; therefore, I agree to inform my Pain Management physician of all medications, prescription and over-the-counter, I am taking for any other medical conditions. I also agree to update ESPM if any changes are made to these medications.
  _____(initial)

- I understand that my medications are prescribed to be used by myself only and I agree not to "share" or give my medications to anyone else. This is **illegal** as well as dangerous for another person. I agree to use my prescriptions exactly as written including the prescribed dose, time, interval or frequency, and route. If I take my medication more often and use up my medications sooner than prescribed, **I UNDERSTAND THAT THEY WILL NOT BE REFILLED EARLY**. I also agree not to use any medications for pain, or my pain condition, from any other source or to use medications given to me by another person.
  _____(initial)

- I understand that some patients develop a tolerance, which is the need to increase the dose of the medication to achieve the same effect in terms of pain relief. I also understand that as a result of other treatment, therapy, or the natural course of my disease process, my pain may change. Therefore, my medication doses will have to be adjusted (increased or decreased) as deemed appropriate by my physician. I will **not** adjust the medication myself.
  _____(initial)

- I understand that my prescriptions must be filled at **one** pharmacy location. I will not change pharmacies without first notifying Eastern Shore Pain Management, and I must have a valid reason before initiating such a change. Pharmacy: _____ Phone: _____

- **I UNDERSTAND THAT IF ANY OF THESE CONDITIONS ARE VIOLATED, MY CARE AT EASTERN SHORE PAIN MANAGEMENT WILL BE TERMINATED.**

_____ _____

Signature Witness

EASTERN SHORE PAIN MANAGEMENT, P.C.
PO Box 2064
Fairhope, AL 36533

Narcotic Safety Contract

The narcotic dosage that you will be taking may seem to have very minimal effect on you as a patient, because you are accustomed to this medication. However, your medication given to a person who is not used to taking the medication can cause a severe reaction, and even death in that person. _____(initial)

Since narcotic medication may be lethal to some persons, it must be guarded at all times. It should be kept in a location where no one, especially children, can tamper with it. It should be placed under lock and key to make it very difficult to obtain. I suggest obtaining a lock box or the equivalent, as you would store a loaded handgun.
_____(initial)

AT THE DOCTOR'S DISCRETION, PATIENTS RECEIVING CONTROLLED SUBSTANCES WILL BE GIVEN A DRUG SCREEN. THIS SCREENING WILL INCLUDE ALL CONTROLLED SUBSTANCES AND ALL ILLEGAL STREET DRUGS. THESE SCREENINGS ARE FOR YOUR SAFETY. MIXING PRESCRIPTION MEDICATIONS WITH OTHER DRUGS AND/OR PRESCRIPTIONS CAN BE DEADLY. THE COST OF THESE SCREENINGS MUST BE PAID AT THE TIME OF THE DRUG SCREEN. REFUSAL TO HAVE THE DRUG SCREEN WILL BE GROUNDS FOR DISMISSAL FROM THE PRACTICE.

_____(initial)

All patients are subject to random drug screens at any point during treatment.
_____(initial)

It is the patient's responsibility to keep up with prescription refill dates. Office policy states that patients who call to ask when their last visit or prescription was will not be given that information._____(initial)

You have previously signed a medication contract with us. Let me emphasize that if you receive any medication from another physician, you should notify me immediately, since the medication could have a different effect than intended while you are taking narcotic medications. Please call me at any time, and I will make the necessary adjustments to your medication.

_____	_____	_____
Patient	Date	Witness

Opiates and Benzodiazepine Drug Interaction Warning

The **U.S. Food and Drug Administration (FDA)** is requiring class-wide changes to drug labeling , including patient information warnings about the serious risks associated with using these medications at the same time. The FDA has implemented the Opioids Action Plan, which focuses on policies aimed at reversing the prescription opioid abuse epidemic nationwide. It's goal is to decrease the rate of deaths related to overdoses by mixing these two drugs.

1. _____(Initials) I understand by mixing opiates and benzodiazepines that it can be extremely dangerous to my health by leading to excessive depression of the nervous system, resulting in respiratory depression and ultimately death.

2._____(Initials)By signing below, I am combining opiates with benzodiazepines against the advice of the warnings listed above. I agree not to hold Eastern Shore Pain Management, Dr. Robert McAlister, Jr. and/or his staff liable for any reactions, overdose, side effects, bodily harm and/ or death.

_____ _____

Patient Name (Print) Date

_____ _____

Patient Signature Date

_____ _____

Witness Date

EASTERN SHORE PAIN MANAGEMENT, P.C.
PO Box 2064
Fairhope, AL 36533
(251) 929-2050

NOTICE OF PRIVACY PRACTICES

Eastern Shore Pain Management (ESPM) is required to protect the privacy of your confidential personal health information referred to below as protected health information ("PHI"). This Notice of Privacy Practices ("Notice") is provided to you as a requirement of the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This notice describes how **ESPM** may use and disclose your PHI to carry out treatment, payment and healthcare operations and for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. **ESPM** will make a good faith effort to obtain from you a written acknowledgement of receipt of this Notice.

In this Notice, **ESPM** provides categories that describe these uses and disclosures and, in some cases, examples are provided to help you better understand each category.

In addition to the privacy protection provided under federal law, Alabama law (referred to in this notice as the Alabama Requirements) requires us in certain situations (i) to get your written consent (or, according to some of the Alabama requirements, written consent from your attorney, guardian, or upon court order) before we can use or disclose your information, or (ii) to keep records of certain events for a period of time that is longer than what is required under HIPAA. The Alabama Requirements may apply:

- If you qualify as a patient that suffers from a sexually transmitted disease;
- If you qualify as a patient that receives benefits from the State of Alabama for certain developmental disabilities or mental retardation;
- If you qualify as a patient that the Alabama Medicaid Program has asked us to serve as a Case Management Provider for;
- If you qualify as a patient that receives rehabilitative services through the Alabama Medicaid Program;
- If you qualify as a patient that receives certain benefits under the Alabama Preventive Health Education Program;
- If you qualify as a patient that receives certain Children's Specialty Clinic Services under the Alabama Medicaid Program.

Uses and Disclosures for Treatment, Payment and Health Care Options.
ESPM may use or disclose your PHI for the purposes of treatment, payment and health care operations, described in more detail below, without obtaining written authorization from you,

For Treatment. **ESPM** may use and disclose PHI in the course of providing, coordinating, or managing your medical treatment, including the disclosure of PHI for treatment activities of another health care provider. These types of uses and disclosures may generally take place between physicians, nurses, technicians, and other health care professionals who provide you health care services or are otherwise involved in your care. For example, if you are being treated by a primary care physician, that physician may need to disclose PHI to a specialist physician whom he or she consults regarding your condition, or to a nurse who is assisting in your care.

For Payment. **ESPM** may use and disclose PHI in order to bill and collect payment for the health care services provided to you. For example, **ESPM** may need to give PHI to your health plan in order to be reimbursed for the services provided to you. **ESPM** may also disclose PHI to its business associates, such as billing companies, claims processing companies and others that assist in processing health claims. **ESPM** may also disclose PHI to other health care providers and health plans for the payment activities of such providers or health plans.

For Health Care Operations. **ESPM** may use and disclose PHI for health care operations, including for quality assessment and improvement. For example, **ESPM** may use and disclose PHI to evaluate the treatment and services you receive and the performance of our staff in caring for you, provider training, underwriting activities, compliance and risk management activities, planning and development, and management and administration of **ESPM**. Other examples of health care operations include disclosure of PHI to doctors, nurses, technicians, students, attorneys, consultants, accountants, and others for review and education purposes, to help make sure **ESPM** is complying with all applicable laws, and to help **ESPM** continue to provide health care to its patients at a high level of quality. In addition, under certain circumstances, **ESPM** is permitted to disclose PHI to other health care providers and health plans for their health care operations, including their quality assessment and improvement activities, credentialing and peer review activities, and health care fraud and abuse detection or compliance.

These uses and disclosures may also be limited by the Alabama Requirements.

Other Uses and Disclosures For Which Authorization is Not Required.
In addition to using or disclosing PHI for treatment, payment and health care operations, **ESPM** may use and disclose PHI without your written authorization under the following circumstances:

As required by law and law enforcement. **ESPM** may use or disclose PHI when required to do so by applicable law. **ESPM** may also disclose PHI (but only under certain circumstances) when ordered to do so in a judicial or administrative proceeding, to identify of locate a suspect, fugitive, material witness, or missing person, when dealing with gunshot and other wounds, about criminal conduct, to report a crime, the location of the crime or victims, or the identity, description, or location of a person who committed a crime, or for other law enforcement purposes.

For Public Health Activities and Public Health Risks. **ESPM** may disclose PHI (but only under certain circumstances) to government officials in charge of collecting information about births and deaths, preventing and controlling disease, reports of child abuse or neglect and of other victims of abuse, neglect, or domestic violence, reactions to medications or product defects or problems, or to notify a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition and other similar activities permitted by law.

For Health Oversight Activities. **ESPM** may disclose PHI to the government for oversight activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities necessary for monitoring the health care system, government programs, and compliance with civil rights laws.

Coroners, Medical Examiners, and Funeral Directors. **ESPM** may disclose PHI to coroners and medical examiners (and may use PHI if acting those capacities) for the purpose of identifying a decedent, determining a cause of death, or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law. In addition, **ESPM** may disclose PHI to a funeral director as permitted by law and as needed to carry out his or her duties.

Organ, Eye, and Tissue Donation. **ESPM** may release PHI to organ procurement organizations to facilitate organ, eye, and tissue donation, and transplantation.

Research. Under certain circumstances, **ESPM** may use and disclose PHI

for medical research purposes.

To Avoid a Serious Threat to Health or Safety. Under certain circumstances, **ESPM** may use and disclose PHI to law enforcement personnel or other appropriate persons to prevent or lessen a serious threat to the health or safety of a person or the public.

Specialized Government Functions. **ESPM** may use and disclose PHI of military personnel and veterans under certain circumstances. **ESPM** may also disclose PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities, and for the provision of protective services to the President or other authorized persons or foreign heads of state or to conduct special investigations. If you are an inmate of a correctional institution or under the custody of a law enforcement official, **ESPM** may disclose your PHI to the correctional institution or official in certain circumstances.

Workers' Compensation. **ESPM** may disclose PHI to comply with workers' compensation or other similar laws. These programs provide benefits for work-related injuries or illnesses.

Appointment Reminders, Health-related Benefits and Services; Marketing. **ESPM** may use and disclose your PHI to contact you and remind you of an appointment at **ESPM**, or to inform you of treatment alternatives or other health-related benefits and services that may be of interest to you, such as disease management programs. **ESPM** may use and disclose your PHI to encourage you to purchase or use a product or service through a face-to-face communication or by giving you a promotional gift of nominal value without obtaining your express authorization.

Disclosures to You, or for your HIPAA Compliance Investigations. **ESPM** may disclose your PHI to you or to your personal representative (who generally is someone who has the legal authority to act on you behalf), and is required to do so in connection with your rights described below. **ESPM** also must disclose your PHI to the Secretary of the United States Department of Health and Human Services (the "Secretary") when requested by the Secretary in order to investigate the compliance of **ESPM** with HIPAA.

These uses and disclosures may also be limited by the Alabama Requirements.

Uses and Disclosures That May be Made With Your Agreement or Opportunity to Object. You will have the opportunity to agree or object to these uses and disclosures of PHI that **ESPM** may make:

Disclosures to Individuals Involved in Your Health Care or Payment for Your Health Care. Unless you object, **ESPM** may disclose some of your PHI to a family member, other relative, friend, or other persons you identify. **ESPM** may also notify those people about your location or condition. When you are unable to agree or object, **ESPM** may still disclose your PHI in certain circumstances.

These uses and disclosures may also be limited by the Alabama Requirements.

Uses and Disclosures of PHI For Which Authorization is Required. Other types of uses and disclosures of your PHI not described in this Notice will be made only with your written authorization, which you have the right, with some limitations, to revoke in writing.

Regulatory Requirements. **ESPM** is required by law to maintain the privacy of your PHI, to provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to abide by the terms described in this Notice. (That is, the version that is currently in effect.) **ESPM** reserves the right to change the terms of this Notice and of its privacy policies and to make the new terms applicable to all of the PHI it maintains. Before **ESPM** makes an important change to its privacy policies, it will promptly revise this Notice and post a new Notice in our waiting room.

Individual Rights.. You have the following rights regarding your PHI:

- You may request that **ESPM** restrict the use and disclosure of your PHI. **ESPM** is nit required to agree to any restrictions you request, but if **ESPM** does so it will be bound by the restrictions to which it agrees except in certain emergency situations.

- You have the right to request that communications of PHI to you from **ESPM** be made by particular means or at particular locations. For instance, you might request that communications be made at your work address, or by e-mail rather than regular mail. Your requests must be made in writing and sent to our Privacy Officer. **ESPM** will accommodate your reasonable requests.

- Generally, you have the right to inspect and copy your PHI that **ESPM** maintains, provided that you make your request in writing to our Privacy Officer. If you request copies of your PHI, **ESPM** may impose a reasonable fee to cover copying, postage, and related costs. **ESPM** may deny access in certain circumstances. If **ESPM** denies access to your PHI, it will explain the basis for denial and whether you have an opportunity to have your request and the denial reviewed by a licensed health care professional (who was not involved in the initial denial decision). If **ESPM** does not maintain the PHI you request, if it knows where that PHI is located it will tell you how to redirect your request.

- If you believe that your PHI maintained by **ESPM** contains an error or needs to be updated, you have the right to request that **ESPM** correct or supplement your PHI. Your request must be made in writing to our Privacy Officer, and it must explain why you are requesting an amendment to your PHI. In certain circumstances, you have the right to amend your PHI. We may deny your request in certain circumstances.

- You generally have the right to request and receive a list of certain disclosures of your PHI **ESPM** has made at any time during the six (6) years prior to the date of your request (provided that such a list would not include disclosures made prior to April 14, 2003). You should submit any such request to the Privacy Officer. **ESPM** will provide the first list to you at no charge, but if you make more than one request in one year, you may be charged a reasonable fee for each additional request **ESPM** will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred to you.

- You have the right to receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact our Privacy Officer.

- You may complain to **ESPM** if you believe your privacy rights with respect to your PHI have been violated by contacting our Privacy Officer. **ESPM** will in no manner penalize you or retaliate against you for filing a complaint regarding **ESPM's** privacy practices. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services.

If you have any questions about this Notice, please contact us at the address on the first page of this Notice.

Effective Date: April 14th, 2003.

ACKNOWLEDGEMENT FORM

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Eastern Shore Pain Management, P.C.'s Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information.

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ Witnessed by: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)
Relationship: _____ Witnessed by: _____

If the patient refuses to sign, indicate your attempt to obtain a signature below.

( ) Patient refused to sign this Acknowledgement

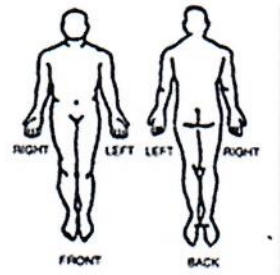
Date: _____
Time: _____
Employee Name: _____

Name:_____ Date:_____ B/P:____/____ Pulse:____ Temp:____ Wt:____ Ht:____

1. Where is your worst area pain today?_____ Circle One: Occasional (sometimes) Continuous (always)
   Does it spread/go/run to another area? Where?_____

2. Circle the words that describe your pain:

aching	sharp	penetrating	throbbing	tender
nagging	shooting	burning	stabbing numb	dull
gnawing	tiring	exhausting	unbearable	other_____



Mark Your Pain Location

3. Circle the number that describes your pain **right now**:
   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

4. Have you had any pain free days? _____

5. Have you tried to skip any pain medication doses? What happened? _____

6. What makes your pain **better** (hot, cold, activity, stress, emotions, etc.)? _____

7. What makes your pain **worse**? _____

8. Emotionally I: (circle what applies)

Feel sad or depressed	Have suicidal thoughts	Have low self-esteem	Avoid places where I get anxious
Feel worthless	Feel stressed	Feel irritable	Have anxiety/ panic attacks
Have trouble concentrating	See myself as unable to cope	Have less interest in pleasurable things	

9. What **treatments** or **medications** are you receiving for your pain? (Manipulation, facet inj, pain pills, prolo physical therapy, TENS, etc.)
   Circle the number to show relief of that treatment:

a. _____	No pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as you can imagine
b. _____	No pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as you can imagine
c. _____	No pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as you can imagine
d. _____	No pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as you can imagine

10. What **side effects** or **symptoms** are you having? Circle the number to describe your experience since last visit:

a. Nausea	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe enough to stop medicine.
b. Vomiting	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe enough to stop medicine.
c. Constipation	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe enough to stop medicine.
d. Lack of Appetite	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe enough to stop medicine.
e. Tired	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe enough to stop medicine.
f. Itching	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe enough to stop medicine.
g. Nightmares	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe enough to stop medicine.
h. Sweating	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe enough to stop medicine.
i. Difficulty	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe enough to stop medicine.
j. Insomnia	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe enough to stop medicine.

k. Other_____

11. Circle the number that shows how **pain interfered** with the following:

a. General Activity	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes (what can't you do?) _____
b. Mood	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes
c. Normal Work	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes
d. Sleep	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes (how) _____
e. Enjoyment of life	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes (how) _____
f. Concentration	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes
g. Relation with other	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes (describe) _____

h. Other _____

Please read and Initial the following statements:

____I will not share, sell, or trade my medication with anyone.
____I will not take medication prescribed for another individual.
____I will bring all prescription medications/ bottles with me for review by the staff at each visit.
____I understand that lost or stolen medication will not be replaced at all.
____I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication until my scheduled appt. **I will call if I have increased pain prior to that time.**
____I understand that I might have a drug screen at any time which is not covered by insurance.

Patient:_____ Date: _____ **OFFICE ONLY (ESPM):** _____

Patient Questionnaire

	Yes	No
1. Have you ever had TB (Tuberculosis)?	☐	☐
2. Have you been living with anyone in the past 2 years who has been diagnosed with TB?	☐	☐
3. Have you had a persistent cough and fever for more than 2 weeks?	☐	☐
4. Have you had a persistent cough and night sweats for more than 2 weeks?	☐	☐
5. Have you had a persistent cough and loss of appetite for more than 2 weeks?	☐	☐
6. Have you been coughing up or spitting up bloody sputum (saliva)?	☐	☐

Patient Signature _____

Date _____