# Rocky Mountain Pain Specialists

16830 Northgate Dr. Suite 130
Parker, CO 80134
Phone (303) 805-7246
Fax (303) 840-7159
www.rmpainspecialists.com

## New Patient Paperwork

### PATIENT INFORMATION

Patient Name (please print) _____

Address_____

City _____State_____ Zip_____

Date of Birth_____ SSN_____

Phone # _____Cell #_____

Email_____

Marital Status: _____ # of Children_____ Highest Level of Education_____

Employer_____Phone_____

Primary Care Physician_____Phone_____

Referring Physician_____Phone_____

Primary Language Spoken _____ Interpreter Needed: Yes No

### EMERGENCY CONTACT

*(relative or friend not living with you)*

Name _____Phone_____

Relationship _____

### REASON FOR VISITING

_____

_____

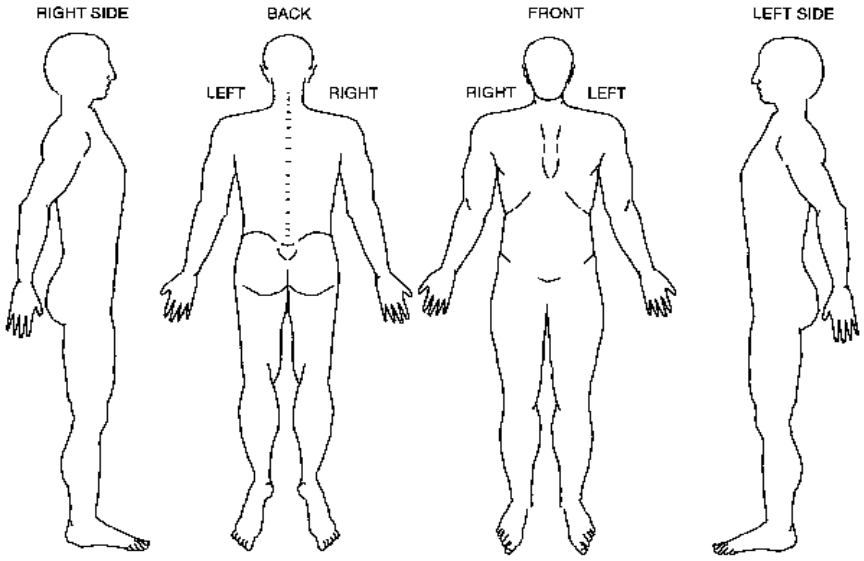
_____

_____

# PAIN INFORMATION

- Where is your main pain problem located? Please mark area on drawing below accordingly.

------ Numbness
oooo Pins & Needles
^^^^ Burning
xxxxx Aching
\\\\\ Stabbing




- When did your pain begin?_____
- Is your pain related to a trauma, injury, fall, accident, etc.? Provide brief details

_____

_____

- Have you had this pain before?_____
- How have you treated your pain in the **past**? Fill all that apply.
  - TENS UNIT / BACK BRACE
  - Physical Therapy, Dates: _____
  - Acupuncture, Dates: _____
  - Chiropractor, Dates: _____
  - Massage Therapy, Dates: _____
  - Injections, Dates: _____
    - Types: _____
  - Past Medication used (circle on the table below) if not, please specify: _____

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Ibuprofen | Tylenol | Naproxen | Mobic | Etodolac | Diclofenac | Flexeril | Baclofen | Lyrica | Zanaflex |
| Norflex | Soma | Gabapentin | Nortriptyline | Amitriptyline | Horizant | Gralise | Cymbalta | Vicodin | Norco |
| Percocet | Morphine | Tramadol | Oxycodone | Fentanyl | Dilaudid | MS Contin | OxyContin | Opana | Nucynta |

- How are you managing your pain now?_____

  _____

- How would you characterize your pain? Check all that apply.

  ❑ Burning ❑ Stabbing ❑ Aching ❑ Throbbing ❑ Sharp ❑ Dull

- On a scale of 1 to 10, with 10 being the worst pain possible and 0 being no pain, how would you rate your pain on average?

  _____

  What is your pain score right now?_____

- Does your pain radiate into your extremities or other parts of your body? Yes No

  If so, please mark where on drawing above accordingly.

- What alleviates your pain?_____

- What aggravates your pain?_____

- Has your pain interfered with (mark all that apply)?

  ❑ Household chores ❑ Physical Activity ❑ Work
  ❑ Shopping ❑ Recreational Activities ❑ Sexual Activity
  ❑ Sleeping ❑ Relationships with Family/Friends

# HEALTH SUMMARY

## LIST ALL CURRENT MEDICATIONS

*(Include birth control, herbals, vitamins, dietary supplements and over-the-counter)*

| Name | Dose | Frequency | | Name | Dose | Frequency |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## ALLERGIES

❑ No Known Drug Allergies_____

| Drug | Reaction | | Drug | Reaction |
|---|---|---|---|---|
| | | | | |
| | | | | |

## SURGICAL HISTORY

| DATE | OPERATION | HOSPITAL | SURGEON |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## PRESENT OR PRIOR HEALTH CONDITIONS

*(Check all that apply)*

| YES | NO | DISEASE | | YES | NO | DISEASE |
|---|---|---|---|---|---|---|
| | | Heart Attack/Coronary Artery Disease | | | | Prostate Problems |
| | | Congestive Heart Failure | | | | Gout |
| | | Irregular Heartbeat | | | | Arthritis |
| | | Heart Murmur | | | | Skin Disease, Type: |
| | | Pacemaker | | | | Stroke |
| | | High Blood Pressure | | | | Epilepsy / Seizures |
| | | High Cholesterol | | | | Diabetes |
| | | COPD / Emphysema | | | | Thyroid Problems |
| | | Asthma | | | | Cancer, Type |
| | | Sleep Apnea | | | | Anxiety |
| | | Tuberculosis | | | | Depression |
| | | Blood Clot in Lung | | | | Bipolar Disorder |
| | | Blood Clot in Leg | | | | Emotional, Physical, Sexual Abuse |
| | | Bleeding Problem, Type: | | | | Substance Abuse |
| | | Anemia / Low Blood | | | | Psychiatric Disorder, Type: |
| | | Gallstones | | | | Sleep Disorder, Type: |
| | | Liver Disease, Type: | | | | Concussion(s) |
| | | Ulcers in Bowel / Stomach | | | | Spinal Cord Injury |
| | | Acid Reflux | | | | Multiple Sclerosis |
| | | Bleeding from Bowels | | | | HIV / AIDS |
| | | Kidney Disease, Type: | | | | Fibromyalgia |
| | | Kidney Stones | | | | Other: |

## REVIEW OF SYSTEMS

*(Circle those that apply)*

**General:** Fevers | Chills | Night Sweats | Unintentional Weight Loss/Gain
**Eyes:** Blurred | Double Vision | Tearing
**Ears, Nose, Throat:** Difficulty Swallowing | Hearing Loss | Chronic Sinus Infections
**Cardiovascular:** Chest Pain | Chest Tightness | Palpitations
**Respiratory:** Shortness of Breath | Chronic Cough | Sputum
**Gastrointestinal:** Nausea | Vomiting | Diarrhea | Constipation | Abdominal Pain | Blood in Stool
**Genitourinary:** Incontinence | Frequency | Burning | Dribbling | Rectal Numbness
**Musculoskeletal:** Joint Pain | Swelling | Deformity | Redness | Stiffness
**Skin:** Rash | Lumps | Bumps | Change in Nail Texture | Coolness | Warmth
**Neurological:** Loss of Balance, Dizziness, Headache, Weakness
**Endocrine:** Heat or Cold Intolerance
**Hematologic:** Easy Bleeding / Bruising, Difficulty with Stopping Bleeding
**Immunologic:** Frequent Infections, Need for Antibiotics Before Procedures

## SOCIAL HISTORY

1. Do you smoke? Yes No If yes, how many years? _____ Packs/Day? ____
2. Have you quit smoking? Yes No Year Quit_____
3. Do you drink alcohol? Yes No If yes, Amount _____ Per Month Week Day (circle)
4. History of drug abuse? Yes No
5. History of alcohol abuse? Yes No
6. Do you currently use recreational drugs? Yes No

   If yes, which? _____
7. What is your current/most recent occupation? _____
8. What is your current employment status? _____
9. What are your hobbies/interests? _____
10. Do you currently exercise? Yes No If yes, how often? _____
11. Are you receiving compensation or disability payments now? Yes No
12. Do you have an application for compensation or disability pending? Yes No If yes, what is the current status?

    _____

## FAMILY HISTORY

| YES | NO | DISEASE | RELATION | | YES | NO | DISEASE | RELATION |
|---|---|---|---|---|---|---|---|---|
| | | Heart Attack | | | | | Bleeding Problem | |
| | | High Blood Pressure | | | | | Sickle Cell Anemia | |
| | | Asthma | | | | | Diabetes | |
| | | Liver Disease | | | | | Thyroid Problem | |
| | | Kidney Disease | | | | | Cancer<br>Type: | |
| | | Gout / Arthritis | | | | | Alcohol or<br>Substance Abuse | |
| | | Osteoporosis | | | | | Anxiety or Depression | |
| | | Stroke | | | | | Glaucoma | |
| | | Epilepsy/Seizure | | | | | Scoliosis | |
| | | Neuromuscular<br>Disorder, Type: | | | | | Other: | |

# RMPS Office Policies

**Our Mission:**
At Rocky Mountain Pain Specialists, we provide high-quality patient care through a multidisciplinary approach in the evaluation and management of acute and chronic pain syndromes. Our goal is to appropriately provide the greatest pain relief possible in order to improve function and the quality of life for our patients.

**Office Hours:**
Monday – Friday 8:00am-5:00pm with lunch break between 12:00pm-1:00pm.

**Appointments:**
Appointments will be scheduled during regular clinic hours. If you are unable to keep your appointment, please inform our staff as far in advance as possible. If you call to CANCEL your appointment within less than 24 hours or NO SHOW to your scheduled appointment you will be charged a fee of $100.00. For any injection or procedure "NO Shows" as well as appointments cancelled with less than 24 hours a $300 .00 fee will be charged to your account. In addition, if you continue to NO SHOW or CANCEL your appointments, you will be discharged for three (3) total appointment "No Shows" as well as appointment cancellations. Discharge letter notice will be sent via mail.

Remember that it is the responsibility of the patient to be at your scheduled checked in appointment time, reminder calls are a courtesy. Our EMR, Athena will call/text you 9, 3 and 1 day prior to your scheduled appointment. If you are more than 10 minutes late your appointment may be rescheduled.

**Compliance:**
Pain is best addressed through a multimodal approach. As such, your provider may recommend certain therapies, medical equipment, interventions, medications, referrals, manual manipulation, home exercises, and/or counseling. You are expected to adhere to your treatment plan in order to manage your pain appropriately. If you fail to do so for what is deemed to be insufficient reason by your provider, your ongoing care at RMPS may be suspended due to non-compliance with treatment.

**Possession of Controlled Substances:**
It is RMPS policy that patient will not possess, use or be under the influence of controlled substances while being seen in our offices or on our property, including the parking lot and surrounding area. Patients may not use or smoke marijuana or other scheduled substances on the premises. Failure to comply may result in being discharged from our clinic.

**Phone Calls:**
The reception desk will return phone calls in order of urgency. All calls will be returned Monday – Friday within 24 business hours of the time the call was received. We will not return calls over weekends.

**Prescription Refills:**
Prescription refills will only be given during scheduled office visit or regular business hours with a 48 hour advance notice. Strictly enforced: Narcotic refills will only be handled during a scheduled office visit. It is the responsibility of the patient to keep their scheduled appointment to ensure that the prescription can be refilled in a timely manner so you don't run short of medications. See Medication Policy & Agreement for further details.

**Financial Policy:**
Payment methods accepted include Cash, Debit/Credit Cards (Visa, Discover, and MasterCard). Regenerative medicine program payment is due in accordance with the financial agreement that will be reviewed and agreed upon following the initial examination.

**Insurance & Co-Pays:**
RMPS will help facilitate insurance eligibility, but it is ultimately the patient's responsibility to contact your insurance to ensure you are eligible for services. Additionally, insurance requires that **Co-pay** payment is due in full at the time of service, no exception. If you cannot provide your co-payment, we may reschedule your appointment.

**Special Medical Forms:**
At this time, RMPS does not complete functional capacity evaluations or disability, work release forms, etc. These requests will be referred back to your primary care doctor.

**Delinquent Accounts:**
If your account is delinquent, you will receive a letter from our Billing Department notifying you that you need to make a payment to clear your account, or if you cannot pay the whole bill, payment arrangements through the Billing Department will be expected. If payment is not made, your account will be turned over to a collection agency and you will no longer be offered services at RMPS until this matter has been settled.

**Appropriate Conduct:**
We have a ZERO tolerance policy for any patient who behaves or speaks inappropriately to clinical staff, office staff, and/or physicians. Such conduct will result in discharge from our clinic immediately. Patients may not continually call Rocky Mountain Pain Specialists to discuss non-urgent medical issues, as this should only occur during your office appointment. Our practice is not an urgent care or ER facility. If a new injury or pain problem occurs you will need to contact your primary care doctor or visit an appropriate facility to handle any medical emergency or changes in current health.

I, _____ have read this form and the general office policies form in its entirety or have had it read to me. I understand all of it and have had an opportunity to have all of my questions regarding this treatment answered to my satisfaction. I agree that this agreement is essential to my medical care and the ability to treat my pain effectively, and that my failure to comply with the terms of this Agreement may result in the following: 1) Withdrawal of all prescribed medication and regenerative services by Rocky Mountain Pain Specialist physicians or providers. 2) Termination of the physician-patient relationship. 3) Immediate discharge by Rocky Mountain Pain Specialists. By signing this form, I understand the requirements of becoming a patient at Rocky Mountain Pain Specialists and consequences of failing to adhere to these requirements.

_____
Printed Name

_____
Signature

_____
Date

## RMPS Medication Policy

The prescription of narcotics for pain management is a challenge under the best of circumstances due to issues of substance abuse, addiction, legal requirements, and the historical high percentage of drug abusers intermingled with the chronic pain population. In order to continue to prescribe narcotics to patients, it is necessary to have tight controls and rigid rules established to eliminate those who obtain narcotics for illegal use or substance abuse, to protect the privileges of our practice to prescribe, maintain the health and well-being of patients, and to obey the federal and state laws under which we operate.

Narcotics have many serious risks, including but not limited to: the potential for addiction and substance abuse, unintentional overdose, misuse and diversion, physical dependence and tolerance, interactions with other medications and substances, and even increased pain over time. Side effects of narcotics include sedation, respiratory depression, swelling in the feet, dental decay acceleration, hives, itching, slurred speech, impaired thinking and function to the point a person may be dangerous when driving or operating machinery, ICU admission, coma, and death. For these reasons and more, we reserve the right to change to a non-narcotic therapy at any time it is medically indicated. We also reserve the right to insist on inpatient or outpatient therapy for narcotic dependence. There is no implied or expressed patient right to narcotic therapy in a physician's office or in a hospital. If you are a new patient, understand that we do not guarantee, nor is it typical, for narcotic medications to be prescribed at your initial appointment. Please be aware that you may be asked to submit a urine or saliva sample before any prescription is given, including narcotics. It is also possible that you may have a brief waiting period before medications can be prescribed pending the results of your urine or saliva sample.

This agreement is between the Patient and Rocky Mountain Pain Specialists (RMPS) for establishing clear conditions for the prescription and use of pain-controlling medications or controlled substances prescribed by this medical practice for the Patient. Both parties agree that this agreement is essential in maintaining the trust and confidence in the Provider / Patient relationship.

When controlled substances (opiates, narcotic analgesics, and sedatives) are prescribed, communications must be clear, as the Drug Enforcement Administration (DEA) monitors the prescription and use of such medications closely. It is understood that these medications do not cure pain conditions, may cause other serious problems, and are used at the sole discretion and decision of the treating Provider.

By initializing and signing below, the Patient agrees to and accepts the following conditions for the management of pain medication prescribed by Rocky Mountain Pain Specialists:

**GOALS OF TREATMENT:**

_____ 1. If used, I agree that the main goal of opioid therapy is to reduce pain, improve function and quality life, in regards to both physical and vocational functioning. However, it is understood that the elimination and cure of pain may not be possible, and in such cases, the goal is to minimize pain to allow for maximum functional capacity.

_____ 2. I understand that narcotic medications are one approach of pain therapy and never represent the sole method of pain control. I agree that multiple approaches should be used to control my pain, including, but not limited to, non-opioid medications, daily home exercise, physical therapy, chiropractic manipulation, interventional treatments, pain psychology, functional capacity assessment, alternative therapies and/or surgical intervention; and that all appropriate avenues of pain therapy will be investigated to minimize my opioid needs.

_____ 3. In compliance with the Colorado Department of Regulatory Agencies, "Policy for Prescribing and Dispensing Opioids", I agree that opioid doses greater than 120 mg morphine equivalents per day may be dangerous and that the use of opioids for greater than 90 days may suggest ineffective treatment. During the course of my care at RMPS, all attempts will be made to achieve this recommendation when possible. It will be up to my provider to determine if and when an exception may be made, and the duration for which such an exception will be made.

_____ 4. I agree that RMPS is providing specific medical expertise in pain management, and when my pain and medication management needs stabilize or plateau, that I may be discharged to my primary care physician or another provider for ongoing care and medical management. However, I may still be seen in this clinic on a less frequent, biannual or annual basis to ensure ongoing appropriate management. Should my pain worsen at any point, become poorly controlled, or a new pain condition develop, I understand that I may return for repeat evaluation and further treatment.

**REQUIREMENTS FOR APPROPRIATE PATIENT BEHAVIOR, RESPONSIBILITY & COMPLIANCE WITH TREATMENT:**

_____ 1. **Rocky Mountain Pain Specialists will be the only entity prescribing narcotics** for pain while I am under the care of this medical practice. If there is an acute or new condition for which I must urgently seek care elsewhere, **I will notify any treating providers of this contractual agreement and will provide the provider(s) with an electronic or hard copy of this agreement for them to sign off on and return to RMPS. I will also notify RMPS (within 24 hours)** of the situation regarding the other provider's treatments and prescriptions. At that time, my pain medications with this clinic may be adjusted. If it is discovered that I am habitually or chronically receiving narcotics from other providers, RMPS will immediately discontinue medication prescriptions and notify pharmacies and other treating providers of my substance abuse and **I will be subject to immediate discharge.**

_____2. I will have only **one** pharmacy dispensing my pain medications while I am a patient with Rocky Mountain Pain Specialists, which the clinic uses to protect their prescription privileges. This pharmacy will be Cordant-DTC location. This will be further discussed with my provider at the time of prescription.

_____ 3. **Refills of medications will only be performed during scheduled clinic visits.** I will not have narcotic prescriptions called in or written at the time of patient procedures, therapies or during non-office hours.

_____ 4. **There are no early refills.** I understand that I am expected to ensure that my prescription quantity lasts until my next scheduled office visit, and that **I am to use my medication only at the rate, dose and route as prescribed.** While injury from sudden cessation of narcotics only occurs in very rare circumstances, sudden cessation of high dose narcotics will result in severe abdominal cramping,

severe anxiety, rapid heart rate, elevated blood pressure, nausea, etc. Therefore, I understand it is prudent to use my medications as prescribed rather than run out early and be in violation of RMPS policies, which **may result in my discharge.**

_____ 5. I agree that **I am solely responsible for safeguarding my medication from loss or theft by keeping them in a secure or locked location**, and that the consequence of my failure to do so is that I will be without my prescribed medications until the next scheduled refill date, and that I may be **subject to discharge** from Rocky Mountain Pain Specialists. Prescriptions that are lost, stolen, misplaced, destroyed, etc., will not be refilled without an appropriate, and complete, police report.

_____ 6. I agree that **I will submit to random blood, saliva or urine toxicology screening**, if requested by Rocky Mountain Pain Specialists, to determine my compliance with my pain medication regimen. I understand that there may be a brief waiting period before medications can be prescribed pending results of the screen.

_____ 7. On request, I understand that a pill count of my medications may be necessary and I agree to bring **all of my unused pain medications**, and all empty pain medication containers, boxes, or bottles to all of my appointments for count by RMPS staff.

_____ 8. **I will attend all clinic appointments, treatments/procedures, therapies and consultations as requested by my providers.** I will attend all pain appointments and follow pain management recommendations. I understand that this is integral to managing my pain appropriately, improving my function and minimizing my medication needs, and that **failure to keep appointments may lead to discontinuation of treatment due to non-compliance.**

_____ 9. I agree that any discussion about my treatment or changes to my pain medication regimen will take place **only** during my clinic appointments, and not on the phone, by e-mail, or by letter.

_____ 10. I will telephone RMPS **only** for urgent medical problems, or to change or discuss my appointment schedule. I will not telephone RMPS for prescription refills or new medications unless this agreement is revised as such. If I am allowed at some point in the future to phone in requests for medication refills, it must be with at least 48 hours' notice, no later than 1:00 P.M. on the day of the call. **No refills/new medications will be given on Fridays, holidays or weekends.**

_____ 11. I agree **not** to use or distribute any illegal or illicit drugs, medications, or substances. If I do not comply with this condition I understand that I will be **subject to discharge** from the care of Rocky Mountain Pain Specialists. I understand that I am **strongly recommended against** the use alcohol and/or marijuana while on narcotics and that should I continue to use such substances against this recommendation, I do so **at my own risk** with the potential for severe consequences, including, but not limited to, respiratory depression and death. Additionally, my providers may discontinue any and/or all controlled substance prescriptions at their own clinical discretion and concern if there is objective evidence of active and/or ongoing use of such substances.

_____ 12. I agree that I will not possess, use or be under the influence of controlled substances while being seen in our offices or on our property, including the parking lot and surrounding area. I understand I may not use or smoke marijuana or other scheduled substances on the premises. Failure to comply may result in being discharged from our clinic.

_____ 13. I understand that opioids, when used with certain types of medications and substances, may result in serious adverse consequences, including respiratory depression, coma, and death. **I agree to inform Rocky Mountain Pain Specialists regarding any medication prescribed by other physicians, including, by not limited to, anxiety medications (benzodiazepines), muscle relaxants, narcotics, alcohol, marijuana, etc., and that if I am not sure what type of medication it is, I will notify RMPS immediately before taking new medications.** I also express understanding that I must be extremely careful always when utilizing such medications together with narcotics due to their additive and possible synergistic effects.

_____ 14. I agree that if I have a comorbidity of a diagnosed psychiatric condition or mood disorder of any kind, whether acute, subacute, or chronic, I will work to ensure that this is being properly managed by a mental health provider or physician. I understand that optimizing my mental health is integral to managing my pain, and if I fail to comply with such treatment and management to the satisfaction of my provider, my medical treatment at RMPS may be suspended or discontinued for reasons of safety and/or non-compliance.

_____ 15. I agree that under no circumstance should I drive or operate heavy machinery while under the influence of opiate medications, which may impair my judgment, and that such activities may result in severe civil and/or criminal penalties. Should I choose to do so, I understand that I do so at my own risk of injury or death.

_____ 16. I realize that controlled substances are regulated by the federal Drug Enforcement Administration (DEA), and I agree **NOT** to share, sell, or trade my medication for money, goods, services, or any other purposes. In all events where the misuse or abuse of controlled substances are deemed felonies under federal law, there shall be no protection under the Provider / Patient relationship and any information received regarding the commission of a felony will be reported to the police or the DEA without exception.

_____ 17. I waive any applicable right or privilege of confidentiality with respect to the prescribing of my pain medication, and I authorize Rocky Mountain Pain Specialists and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency or authority in the misuse, sale, or other diversion of my pain medication. I authorize RMPS to provide a copy of this agreement to my pharmacy and other physicians designated by me, and acknowledge that I have received a copy myself.

_____ 18. I agree to allow Rocky Mountain Pain Specialists to discuss my medical care and management with any of my other medical care providers or physicians.

## PROCESS & REASONS FOR MODIFYING/DISCONTINUING TREATMENT:

_____ 1. I understand that I will be periodically re-evaluated and my case reviewed. Narcotic therapy may be modified or discontinued with the possibility of a drug taper if: my underlying pain condition is resolved or improved with increased function, intolerable side effects have emerged, my pain relief is inadequate despite escalating doses of narcotics in the absence of any demonstrable worsening findings on clinical exam or imaging, my function has deteriorated, or my quality of life has failed to improve.

_____ 2. Failure to comply in appropriate patient behavior and compliance with my treatment plan (detailed in above section of agreement) may also result in the immediate discontinuation of narcotic therapy. Such examples include: loss of prescriptions, overuse or misuse of medications, external source confirmation of obtaining narcotics chronically from other providers or sources, impairment to the degree of this medical practice that I pose a risk to myself or others, using suicide as a threat or suicidal attempt, arrest for driving impaired, arrest for any alcohol related offense, excessive and frequent calls to RMPS regarding chronic pain issues or medication refills, prevarication regarding prior treatment and substance abuse, cancelling appointments for procedures but presenting for clinic appointments, failure to participate in the integrated therapies of RMPS, etc.

_____ 3. I understand that if I am verbally or physically abusive to any staff member, threaten legal action or violence to obtain narcotics, etc., then the local police will be notified immediately to report a felony drug diversion or attempted extortion, and **I will be discharged immediately from the practice.**

_____ 4. I will not engage in any narcotics-related crime or activity, such as altering prescriptions, selling narcotics, sharing narcotics with others, injection of oral or transdermal narcotics, etc., and understand that there will be **zero tolerance** for such behavior and that all appropriate authorities will be notified and I will be discharged from the practice.

_____ 5. I understand that if I refuse to take a urine, saliva, or blood drug screen on request, refuse to bring in my medications for a pill count when requested, test positive for illicit drug use or narcotics not prescribed by RMPS, or test negative for narcotics that are prescribed by RMPS, that I will be discontinued from all narcotic prescriptions through this clinic. I also may have my care terminated through RMPS terminated.

_____ 6. I understand that if I am discharged from Rocky Mountain Pain Specialist due to non-compliance with this agreement, that I **may** be given prescriptions for a 30-day tapering supply of my medication(s), so as to avoid withdrawal symptoms, however **this agreement in no way mandates a 30-day tapering prescription.**

_____ 7. If I need to dispose of my narcotic medications for any reason, either at the request of my provider(s) at RMPS or my own request, I will do so according to the instructions provided by RMPS and the DEA disposal guidelines, if a DEA take-back or drop box is unavailable. For the safety of myself and others, I agree to NOT dispose of medications on my own.

_____ 8. If I will be traveling out of town and I will not be able to attend my scheduled clinic appointment for such reasons, I agree to supply to RMPS a copies of my gas, hotel and/or airline itineraries and receipts for confirmation. If a new prescription or early refill is necessary due to confirmed travel, it is my responsibility to schedule a clinic appointment before traveling such that prior prescriptions may be disposed of according to RMPS and DEA disposal guidelines and so that a new prescription may be written and filled in a timely manner.

**PATIENT EDUCATION (PROPER USE, RISKS OF ADDICTION, ALTERNATIVES):**

_____ 1. I am aware the use of narcotic medications has certain risks which include, but are not limited to: drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, sexual dysfunction, possible inadequate pain relief, and even increased pain over time.

_____ 2. I will not be involved in any activity that may be dangerous to myself or someone else if drowsy or not thinking clearly, such activities include, but are not limited to: operation of heavy equipment or driving a motor vehicle, working at elevated height without proper protections, being responsible for another individual who is unable to care for themselves. I am aware that even if I am unaware, my reflexes and reaction time might be slowed. I have been advised not to drive while receiving treatment with any medication prescribed without having passed an appropriate driver test, indicating that it is safe to drive.

_____ 3. I understand that physical dependence is a normal and expected result of using medications for a long period of time. Physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medication use is markedly decreased, stopped or reversed, I will experience a withdrawal syndrome. This means that I may have any or all of the following signs and symptoms: runny nose, large pupils, goose bumps, abdominal pain/cramping, diarrhea, irritability, body aches or flu-like symptoms. I am aware opioid withdrawal is uncomfortable but **NOT** life threatening.

_____ 4. I am aware addiction is defined as the use of a medication even if it causes harm, cravings for a drug, feeling the need to use a drug, and having a decreased quality of life. I am aware there is a chance of becoming addicted to my pain medication, but accept that the risk is low. I am aware the development of addiction is much more common in a person who has a family or personal history of addiction. **I agree to tell my provider my complete personal drug history and that of my family to the best of my knowledge.**

_____ 5. I am aware that tolerance to analgesia means that I may require more medication to obtain the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a major problem for most patients with chronic pain; however, such tolerance may have unacceptable adverse effects. Tolerance or failure to respond well to opioid treatment may cause my provider to choose another form of treatment.

_____ 6. (MEN Only) I am aware that long-term opioid use has been associated with low testosterone level. This may affect my mood, stamina, sexual desire/drive and physical and sexual performance. I understand that my provider may check my blood to see if my testosterone level is normal.

_____ 7. (WOMEN Only) If I plan to become pregnant or believe that I am pregnant while taking this pain medication, I will immediately call my OB and this office to inform them I am pregnant. I am aware that, should I carry a baby to term while I am taking these medications, the baby will be physically dependent upon opioids. I am aware that the use of opioids is not usually associated with the risk of birth defects, however, there is always a possibility that my child will be born with a birth defect if I take and opioid while pregnant.

I, _____ have read this form and the general office policies form in its entirety or have had it read to me. I understand all of it and have had an opportunity to have all of my questions regarding this treatment answered to my satisfaction. I agree that this agreement is essential to my medical care and the ability to treat my pain effectively, and that my failure to comply with the terms of this Agreement may result in the following: 1) Withdrawal of all prescribed medication and regenerative services by Rocky Mountain Pain Specialist physicians or providers. 2) Termination of the physician-patient relationship. 3) Immediate discharge by Rocky Mountain Pain Specialists. By signing this form, I voluntarily give my consent for the treatment of my pain with opioid pain management medications and agree to abide by these policies.

This Agreement is entered into on this _____day of _____, 20_____

_____
Patient Name

_____ _____
Patient Signature ER/Urgent Care/PCP Provider

Shaun Gabriel, MD _____
RMPS Physician/Medical Director ER/Urgent Care/PCP Provider Signature

_____ _____
RMPS Physician/Medical Director Date
Rocky Mountain Pain Specialists

# Financial Responsibility Disclosure Statement

This agreement is made and entered into on this _____ day of _____ 20_____ between _____ and RMPS of medical services, hereinafter referred to as RMPS and you the patient receiving medical services, herein after referred to as PATIENT. All Charges for medical services rendered by RMPS are due and payable by PATIENT at the time of service.

By initializing and signing below, the Patient agrees to and accepts the following statements:

**ASSIGNMENT OF BENEFITS AUTHORIZATION:**

_____ PATIENT authorizes and assigns payment of benefits due to PATIENT under terms of any insurance policy or policies that may cover the medical procedure performed on PATIENT by RMPS at the address designated by RMPS on any claim form submitted to PATIENT's insurance carrier. PATIENT agrees that payment to RMPS pursuant to this assignment authorization by PATIENT's insurance company shall discharge said insurance company of any and all obligations under PATIENT's policy to the extent of such payment. PATIENT understands and agrees that PATIENT is financially responsible for charges not covered by PATIENT's assignment authorization, and PATIENT authorizes RMPS to contact PATIENT's employer for the purpose of determining the existence of any insurance benefits.

**MEDICAL INSURANCE:**

_____ As a courtesy to PATIENT, RMPS will verify PATIENT's coverage and bill relevant insurance carrier(s). However, PATIENT is ultimately responsible for payment of bills and any deductibles or co-payment / co-insurance as determined by PATIENT's insurance carrier contract. Co-payment / co-insurance are due and payable at the time of service (NO EXCEPTIONS). If PATIENT's insurance carrier denies any part of claim, or if RMPS elects to continue past PATIENT's approved period, PATIENT is responsible for the balance in full. Cash PATIENTS are required to pay in full at the time of service. Regenerative medicine program payment is due in accordance with the financial agreement that will be reviewed and agreed upon following the initial examination. Further, PATIENT is required:

_____ 1. To present current official identification prior to each visit e.g. driver's license and insurance card(s).

_____ 2. To advise RMPS's office of current address and phone number(s).

_____ 3. To verify at each, visit that PATIENT's information is current by completing and signing RMPS's Patient History Information form, Updated Patient History form or other relevant data forms.

_____ 4. To be aware of how PATIENT's insurance coverage works e.g. any referral authorization PATIENT may require, including designated labs, imaging facilities e.g. X-ray and mammogram.

_____ 5. To pay any additional monies owing within 30-days of receiving a statement from RMPS's office. (When BPRC's office receives an Explanation of Benefits (EOB) from PATIENT's insurance company, any monies owing will be billed to PATIENT.)

_____ 6. To give RMPS's office 24-hour advance notice if PATIENT wishes to cancel an appointment or PATIENT will be billed a $35.00 cancellation fee.

_____7. PATIENT may be discharged from care for two (2) consecutive or three (3) total appointment "No Shows" as well as four (4) total cancellations. Discharge notice to be sent via certified mail.

**NON-PAYMENT ON ACCOUNT:**

_____ Should collection proceedings or other legal action become necessary to collect an overdue account, PATIENT understands that RMPS has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The PATIENT understand that he/she is responsible for all costs of collection including, but not limited to, all court costs and Attorney's fees, and a collection fee of 50% which will be added to the outstanding balance.

**BILLING:**

_____ To avoid unnecessary costs to PATIENTS, monthly statements will not be sent to PATIENTS. Please note that Athena Billing will make every effort to obtain payment from PATIENT's insurance carrier, however, billing may be delayed due to various issues e.g. medical appeal, carrier request for medical records and other information.

_____ For further questions, PATIENT may contact RMPS's billing service directly at 303-805-7246.

**SELF-PAY:**

_____ If PATIENT does not have health insurance; PATIENT agrees to take responsibility for the full and entire amount of medical services rendered by RMPS.

_____ PATIENT understands that Regenerative Medicine services are rendered on a cash pay basis only and that this cash service is to be paid in full by the PATIENT as described in the financial agreement that will be reviewed and agreed upon following the initial examination.

**RESPONSIBILITY FOR VALUABLES:**

_____ PATIENT understands and acknowledges that RMPS is not responsible for the loss or damage to, or theft of any of PATIENT's or dependents' personal possessions, including, but not limited to money, jewelry, clothing or valuables, while PATIENT or dependent(s) are on RMPS's premises.

**FOR MEDICARE PATIENTS ONLY:**

_____ Authorization to release Information and Payment Request: PATIENT hereby request that payment of authorized Medicare benefits be made on PATIENT's behalf to RMPS for any services rendered by RMPS. PATIENT authorizes any holder of medical or other information about PATIENT to be released to the Health Care Financing Administration or its agents, intermediaries or carriers any information needed to determine these benefits or the benefits payable for related services. PATIENT further understands that deductibles, coinsurance, and any other charges not covered by Medicare are PATIENT's responsibility.

By signing below, PATIENT agrees to accept full financial responsibility as a PATIENT who is receiving medical services from RMPS. PATIENT's signature verifies that PATIENT authorizes assignment of benefits, has read the disclosure statement, understands PATIENT responsibilities, and agrees to the terms and conditions described therein. PATIENT further agrees to abide by items on Attachment 1: Patient Responsibility Information (Physical Exams, Appointments, Labs, Prescriptions, Health Insurance and Billing)

_____
Print Patient Name

_____ _____
Patient Signature | Name of Responsible Party or Legal Representative

_____ _____
Date | Signature of Responsible Party or Legal Representative

_____ _____
Signature of Rocky Mountain Pain Specialists | Relationship to Patient

# RMPS Privacy Policy Notice

As required by the privacy regulations created because of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) this notice describes how health information about you (as a patient of Rocky Mountain Pain Specialists) may be used or disclosed and how you can get access to your individually identifiable health information.

**PLEASE REVIEW THIS NOTICE CAREFULLY.**

**A. Our commitment to your privacy:**

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI.
- Your privacy rights in your PHI.
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Privacy Policy Notice. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

**B. If you have questions about this Notice, please contact:**

Business Manager: Reid Christopherson
Address: 16830 Northgate Drive, Suite 130
Phone: (303) 805-7246

**C. We may use and disclose your PHI in the following ways:**

The following categories describe the different ways in which we may use and disclose your PHI.

- Treatment: Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice including, but not limited to, our doctors and nurses may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

- Payment: Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

- Health care operations: Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

- Disclosures required by law: Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

**D. Use and disclosure of your PHI in certain special circumstances:**
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

- Public health risks: Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
  - Maintaining vital records, such as births and deaths,
  - Reporting child abuse or neglect,
  - Preventing or controlling disease, injury or disability,
  - Notifying a person regarding potential exposure to a communicable disease,
  - Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
  - Reporting reactions to drugs or problems with products or devices,
  - Notifying individuals if a product or device they may be using has been recalled,
  - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
  - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

- Health oversight activities: Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

- Lawsuits and similar proceedings: Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

- Law enforcement: We may release PHI if asked to do so by a law enforcement official:
  - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
  - Concerning a death, we believe has resulted from criminal conduct,
  - Regarding criminal conduct at our offices,
  - In response to a warrant, summons, court order, subpoena or similar legal process,
  - To identify/locate a suspect, material witness, fugitive or missing person,
  - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

- Serious threats to health or safety: Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

- Military: Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

- National security: Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials to protect the president, other officials or foreign heads of state, or to conduct investigations.

- Inmates: Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary under the following circumstances:
  - For the institution to provide health care services to you,
  - For the safety and security of the institution,
  - To protect your health and safety or the health and safety of other individuals.

- Workers' compensation: Our practice may release your PHI for workers' compensation and similar programs.

**E. Your rights regarding your PHI:**
You have the following rights regarding the PHI that we maintain about you:

- Confidential communications: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

- Requesting restrictions: You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the office manager of Rocky Mountain Pain Specialists. Your request must describe in a clear and concise fashion:
  - The information you wish restricted,
  - Whether you are requesting to limit our practice's use, disclosure or both,
  - To whom you want the limits to apply.

- Inspection and copies: You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the office manager of Rocky Mountain Pain Specialists in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

- Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for if the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the office manager of Rocky Mountain Pain Specialists. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that, in our opinion, falls under the following criteria:
  - Accurate and complete,
  - Not part of the PHI kept by or for the practice,
  - Not part of the PHI which you would be permitted to inspect and copy,
  - Not created by our practice, unless the individual or entity that created the information is not available to amend the information.

- Accounting of disclosures: All our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented; for example, the doctor sharing information with the nurse or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the office manager of Rocky Mountain Pain Specialists. All requests for an "accounting of disclosures" must state a time period,

which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

- Right to a paper copy of this notice: You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the office manager of Rocky Mountain Pain Specialists
- Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the office manager of Rocky Mountain Pain Specialists. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

- Right to provide an authorization for other uses and disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: We are required to retain records of your care.

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) this notice describes how health information about you (as a patient of Rocky Mountain Pain Specialists) may be used or disclosed and how you can get access to your individually identifiable health information. We would be glad to provide our patients a text version of this upon request.

I have read and understood the Rocky Mountain Pain Specialist's Privacy Policy Notice.

_____

Printed Name

_____

Signature

_____

Date

## RMPS Rights and Responsibilities Statement

As a patient of Rocky Mountain Pain Specialists, your safety, wellbeing and comfort is of top priority. While a patient with us, it is important to know what your rights and responsibilities are. Please take a moment to review the following list of rights and responsibilities and don't hesitate to ask a member of our administrative staff to clarify any one of these that are unclear to you. We would also be glad to provide our patients who suffer from poor vision with a large text version of this upon request.

**Your Rights:**

- You have the right to be informed of the services Rocky Mountain Pain Specialists provides. Rocky Mountain Pain Specialists provides comprehensive pain assessments as well as several treatment modalities with the goal of managing and treating your pain. If requested, a complete list of services will be made available to you.

- You have the right to receive considerate and respectful care regardless of race, gender, nationality, religious preference, age, sexual orientation, or physical and mental disabilities.

- You have the right to have such factors as spirituality, cultural and psychological variables taken into consideration when care is planned.

- You have the right to receive care in an environment free of abuse, neglect, or harassment.
- You have the right to be called by your proper name.
- You have the right to know the names of all people involved in your care.
- You have the right to be informed by your doctor about your diagnosis and possible prognosis.
- You have the right to be informed of the benefits and risks of treatment, and the expected outcome including unanticipated outcomes.
- You have the right of informed consent before your procedure.
- You have the right to have your pain assessed and participate in decisions about managing your pain.
- You have the right of free will and will not be restrained or secluded in any way that is not medically necessary.
- You will receive full consideration of your privacy and confidentiality in examinations, treatment sessions, and care discussions with your healthcare provider.
- You have the right to ask for communication assistance if you have a visual, speech, or hearing impairment. Should you have a physical impairment, you have the right to request reasonable accommodations to ensure access to the facility.
- You may ask for a chaperone to be present during your examination.
- You and your family members, with your permission, have the right to participate in discussions regarding your care and you have the right to refuse care. Should you choose to not follow the medical advice of the doctor, neither the doctor, the staff, or Rocky Mountain Pain Specialists can be held accountable for the medical consequences.
- You have the right to refuse participation in medical research studies.
- You have the right to be notified of any lapse in malpractice insurance coverage and to seek treatment elsewhere.
- You have the right to receive advanced notice of your discharge from the facility, should the need arise. You can expect to receive information directing you to the appropriate health care provider.
- You can expect that all communications and records regarding your health care are kept confidential, unless disclosure is allowed by law. This includes but is not limited to information disclosed at your request in a signed release, information provided to your Health Insurance Company for the purpose of reimbursement, and the sharing of information between your healthcare providers.
- You have the right to discuss charges submitted on your behalf to your insurance carrier. The Billing Department is always available to answer any questions you may have after receiving your explanation of benefits form, or a patient balance statement.
- You have the right to instruct us on how to proceed should you become incapacitated while within Rocky Mountain Pain Specialists. Advance Directive forms and information will be provided to you at your request. Please read our policy on Advance Directives.
- You have the right to voice any concerns you have regarding your care.

If you have a concern, please ask to speak with the office manager or call (303) 805-7246 and request the office manager. If your concern is not resolved to your satisfaction, you have the right to request a review by one of the following organizations:

Colorado Department of Public Health and Human Services
4300 Cherry Creek S Dr, Denver, CO 80246
1-800-886-7689, ext. 2904

For Medicare Beneficiaries:
www.medicare.gov/ombudsman/resources.asp

**YOUR RESPONSIBILITIES:**

- You are expected to provide complete and accurate information, including your full name, address, and home telephone number, date of birth, Social Security number, insurance carrier and employer, when required.

- You are expected to provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products, and any other factors that pertain to your health.

- You are expected to ask questions when you do not understand information and instructions. If you believe that you cannot follow through with your treatment plan, you are responsible for telling your provider. You are responsible for outcomes if you do not follow the plan of care set for you.

- You are expected to actively participate in your pain management plan and keep the doctor, and other allied healthcare professionals, informed of the effectiveness of your treatment.

- You are expected to treat all staff, other patients, and visitors with courtesy and respect; abide by all facility rules and safety regulations; and be mindful of noise levels, privacy and of the number of people that accompany you to your visit.

- You are to provide complete and accurate information about your health insurance coverage and to pay your bills in a timely manner. Please see our Payment Policies for more information.

- You are expected to keep appointments, or call the office to notify us of any conflicts. Further information regarding this process is found in the General Policies section.

- When necessary, you are expected to provide a responsible adult to transport you home from the facility.

- You are expected to provide Rocky Mountain Pain Specialists with information regarding any living will, power of attorney, or any such directive that could affect your care.

As a patient of Rocky Mountain Pain Specialists, your safety, wellbeing and comfort is of top priority. While a patient with us, it is important to know what your rights and responsibilities are. We would be glad to provide our patients a text version of this upon request.

I have read and understood the Rocky Mountain Pain Specialist's Rights and Responsibilities Statement.

_____
Printed Name

_____
Signature

_____
Date

# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

**HIPAA Privacy Authorization Form**
(Required by the Health Insurance Portability and Accountability Act - 45 CFR Parts 160 & 164)

Print Name: _____ Date of Birth: _____/_____/_____

*******REQUIRED*******
**Acknowledgement of Privacy Practices**
By signing below, I hereby acknowledge that I have received a copy of Rocky Mountain Pain Specialists Notice of Privacy Practices as of the date set forth below.

_____ _____/_____/_____
Signature Today's date

**Acknowledgement of Practice Policies**

_____ _____/_____/_____
Signature Today's date

*******BELOW IS OPTIONAL*******
The following individuals can have both written and verbal access to any of my medical records and information pertaining to my care:

| Name: | Relationship: |
|---|---|
| _____ | _____ |
| _____ | _____ |

_____
Patient's Signature Today's date

# APPOINTMENT POLICY

## Attention all patients:

Due to a long wait list for new appointments, we have implemented a new attendance/appointment policy applicable to all patients at Rocky Mountain Pain Specialists. This is to ensure the best care for all our current and future patients. This policy is effective immediately for all current patients.

- Each patient is given a total of **three (3)** reschedules or cancelled appointments per calendar year. Once **three (3)** cancels or reschedules have been documented, *patient will be discharged and asked to find a new pain management specialist.*
- Check in time is **30 minutes** prior to appointment time.
- If you are late for your **check-in time** you may have to be rescheduled to the next available appointment time. In some cases, the next available appointment may not be for several days.
- Late check-in will be documented in your chart. **Three (3)** documented late check-ins can be cause for discharge.

**Missed Appointment Fee's:**

**PROCEDURE APPOINTMENTS: *$300.00 charged fee* for not showing up, or for canceling the appointment under 48 business hours**

**CLINICAL APPOINTMENTS: *$100.00 charged fee for* not showing up, or for canceling the appointment under 48 business hours**

**These fees are the patient's responsibility and will not be billed to insurances or lien companies.**

Thank you,

Rocky Mountain Pain Specialists and Staff.