Damon Christian Kimes, MD
Deitrick Cox, MD
1300 Upper Hembree Road, Bldg. 100, Suite B
Roswell, Georgia 30076
Tel. (678) 736-7680
Fax (888) 537-5362

Dear _____,

Thank you for contacting our office. Your appointment has been scheduled for _____ at _____. Please plan to arrive 15 minutes prior to your scheduled appointment.

Please complete the attached documents and bring them along with any medical records (consultation notes, pharmacy history, MRI/CT results) and current medications.

FAILURE TO CANCEL SCHEDULED APPOINTMENTS AT LEAST 24 HOURS IN ADVANCE

WILL RESULT IN A $75 NO SHOW FEE.

General Information			
Last Name:		First Name:	
Date of Birth:		Marital Status:	
Sex:		SSN:	
Home Number:		Cell Number:	
Street Address:			
City:		State/Zip:	
Employer Name:			
Employer Full Address:			
Spouse First Name:		Spouse Last Name:	
SSN:		Work Number:	
Employer Name:			
Employer Full Address:			
Insurance & Legal Information			
Primary Insurance:		Group Number:	
Guarantor:		ID:	
Secondary Insurance:			
Guarantor:		ID:	
Attorney:		Phone:	
Emergency Contact Information			
Emergency Contact:			
Home Number:		Cell Number:	
Relationship:			
Signature:		Date:	

Informed Consent for Opioid Treatment

I have agreed to use opioids (morphine-like drugs) as a part of my treatment of chronic pain. I understand that these drugs are very useful, but have a potential for misuse and are therefore closely controlled by the local, state and federal government. Because my physician is prescribing such medication to help manage my pain, I agree to the following conditions. I am aware that failure to abide by any of these conditions will be considered a breach of the contract, and at the sole discretion of my physician , may result in the termination of our physician –patient relationship.

1. I am responsible for my pain medications. I agree to take the medications only as prescribed and to contact my pain clinic physician before making any changes.

    - I understand that increasing my dose without the close supervision of my physician could lead to drug overdose, causing severe sedation, respiratory depression and death.

    - I understand that decreasing or stopping my medication without the close supervision of my physician could lead to withdrawal. Withdrawal symptoms may include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, goose flesh, abdominal cramps and diarrhea. The symptoms can occur 24 to 48 hours after the last dose and can last up to three weeks.

2. I will not request or accept opioid medications from any other physician or individual while I am receiving such medications from my physician at Roswell Pain Specialists.

3. I understand the side effects that are related to opioid medications. Common side effects are nausea and vomiting (similar to motion sickness), drowsiness and constipations. Less common side effects are mental slowing, flushing, sweating, itching, urinary difficulty and jerkiness. These side effects would occur at the beginning of my treatment and often go away within a few days without treatment. It is my responsibility to notify my physician of any side effects that continue or are severe (such as sedation or confusion). I am also responsible for notifying my pain physician immediately if I need to visit another physician or emergency room due to pain or if I become pregnant.

4. I understand that the opioid medication is strictly for my own use. The opioid should never be given to others. If children are in the house, a child-proof top is necessary.

5. I understand I must contact my pain physician before taking Benzodiazepines (drugs like Valium or Ativan), sedative (drugs like Soma, Xanax, or Fiorinal) and antihistamines (drugs like Benadryl). I understand that the combination use of the above drugs and opioids, as well as alcohol and opioids, may produce profound sedation, respiratory depression, blood pressure drop and even death. I cannot consume alcohol or use recreational drugs while on opioids. If consumed, the consequence will be termination from the program.

6. I understand that opioid prescription will not be mailed or called into pharmacy. During the time that my dose is being adjusted, I will be expected to return to the clinic no less

frequently than one time a month. After I have been placed on a stable dose, I will return to the clinic whenever instructed by my physician.

7. I am responsible for my opioid prescriptions. I understand that refill prescription:

   - Can only be written for one- month supply and will be filled at the same pharmacy.
   - Shall be made during regular office hours, Monday through Friday, and can be picked up only in person. Refills will not be made at night, on holidays, or on the weekends.
   - Shall not be made if I “run out early” or “lose a prescription” or spill or misplace my medication. I am responsible for taking medication in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. Replacement prescriptions will be given at the discretion of my physician.
   - Shall not be made as an “emergency”, such as Friday afternoon because I suddenly realize I will “run out tomorrow”. I will call at least one week ahead to schedule pick- up for my prescription.

8. While physical dependence is to be expected after long term use of opioids, signs of addiction (and psychological dependence) shall be interpreted as needed for weaning and detoxification.

   - Physical dependence is common to many drugs, such as blood pressure medications, anti seizure medications and opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal.
   - Addiction is a psychological and behavioral syndrome that is recognized when the patient abuses the drug to obtain mental numbness or euphoria, when the patient shows a drug craving behavior or “doctor shopping,” when the drug is quickly escalated without correlation to pain relief and/or when the patient exhibits such behavior, the drug will be tapered. Such a patient is not a candidate for the opioid trial and he or she may be discharged.
   - Tolerance is a pharmacological property of certain drugs and is defined as a needed for higher doses to maintain the same drug-related effect.

9. I understand that the goals of my pain physician’s treatment plan may include time contingent use of opioids. If it appears to the physician that there is no improvement to my daily function or quality of life from the controlled substance, my opioid may be discontinued. I will gradually taper my medication as prescribed by the physician.

10. I agree to submit to urine and blood screens at any time as determined by my physician to detect the use of both prescribed and non-prescribed medications.

11. I understand that I should not drive or engage in potentially dangerous activities while taking the medication unless approved by my physician(s).

12. I further understand that if I do not follow ant of the above conditions or provision, I may (at my physician's discretion) no longer receiver any type of opioid medication. I also understand that if I have a problem or question with any of the above paragraphs, I must make an appointment to discuss this with the pain physician receive clarification before a problem or crisis situation arises.

13. I authorize the release of any information and hospital records by the pain physician or his or her designee to other healthcare providers, my family, my employer, my insurance company or other reimbursing agencies.

WARNING: The Georgia Criminal Code, 16-13-43(a)(6), makes it a felony not to inform any physician prescribing medication to you of other prescription drugs you are now receiving from other physicians.

I, _____ have read the above information (or it has been read to me), have received a copy of the contract and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in opioid medication therapy.

Patient Signature:		Date:	
Witness Signature:		Date:	
Pharmacy Name:			
Pharmacy Phone:			

Partnership Agreement

The greatest success in chronic pain management comes when there is partnership based on mutual respect between patient and health care provider. As patient and health care provider, we respect each other's rights and accept our individual responsibilities.

The health care provider understands that it is important for patients with pain to know that provider will:

- Listen and try understanding the patient's experience living with pain.
- Accept the patient's reports of pain and response to treatment.
- Thoroughly assess the patient's pain and explore all appropriate treatment options, including those suggested by the patient.
- Explain what is known and unknown about the cause of the patient pain.
- Explain the meaning of test results or specialty visits/consolations, and what can be expected in the future.
- Explain the risks, benefits, side effects and limits of any proposed treatment.
- Respect the patient's rights to participate in making pain management decisions, including the right to refuse some types of treatment.

The patient understands that it is equally important for providers that their patients on opioid pain medications will:

- Take medications only at the dose a time/frequency prescribed.
- Make no charges to the dose or how the medication is taken without first talking to the provider.
- Not ask for pain medication or controlled substances from other providers. The patients will also tell every provider all medications they are taking.
- Arrange for refills only through the provider's clinic during regular office hours. Not ask for refills earlier than agreed upon.
- I will inform my other health care providers that I am taking these pain medications and of the existence of this contract. In event of an emergency, I will provide this same information's to emergency departments providers.
- I will keep all follow up appointments or my treatment may be discontinued
- I will receive medication only from one physician unless it is for an emergency or the medication that is being prescribed by another physician is approved by my physician.

Information about receiving other medication being prescribed that has not been approved by my physician may lead to a discontinuation of mediation and treatment.

- If it appears the medications and treatment s show no signs of benefits to my daily function or quality of life, my physician may taper me off my medications or seek an alternative form of treatment
- I understand that my chronic pain may benefit from, physical therapy, psychotherapy, and/or alternative medical care. If my physician requires any such forms of treatment, I will actively participate to achieve improved quality of life.
- Potential for addiction(compulsive drug not related to pain relief)
- Potential for impaired judgment and/ or motor skills(driving or operating machinery may be hazardous due to effects on the brain and nerves)

For male patients: I am aware that chronic opioid/narcotics use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire, and physical/ sexual performance.

For female patients: To the best of my knowledge I am not pregnant. If I am not pregnant, I will use appropriate contraception /birth control during my course of treatment. I accept that it is my responsibility to inform my physician immediately if I become pregnant. However, birth defects can occur whether or not the mother is on medications and there is always the possibility that my child will have a birth defect while I am taking an opioid.

CONSENT TO TREATMENT AND/ OR DRUG THERAPY

This decision was made because my condition is serious or other treatment have not helped my pain I am aware that the use of the drugs used in my treatment include but are not limited to the above listed side effects and risks.

THIS CONFIRMS that I asked you if you wanted a more detailed explanation of the proposed treatments(s), the alternatives, and the material risk. If you are satisfied with the explanation given, you must sign this document indicating your consent to the use of a controlled substance in treating your chronic pain prior to commencing the treatment.

Patient Signature:		Date:	
Print Name:			

Insurance Authorization & Assignment/Financial Statement

I hereby authorize Roswell Pain Specialists to be my treating providers and to furnish information carries concerning my illness and treatment, and I hereby assign to the Roswell Pain Specialists all payment for medical service rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

I understand that all co-pays, deductibles or co-insurance is due at the time of service, no exception, unless prior arrangements have been made. I am responsible for proving Roswell Pain Specialists with correct insurance information. Roswell Pain Specialists will bill my insurance as a courtesy to me and if my insurance does not pay within 90 days from my dates of service(s). I am aware that I will be billed for the balance and held responsible for the amount in full. I also understand that if I do not satisfy my financial obligation and have an outstanding balance with the clinic; further service to me by Roswell Pain Specialists.

PRIVACY NOTICE

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

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for purpose that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your protected health information means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that related to your past, present, or future physical health or mental health conditions.

A “Privacy Notice” is available upon request for your review, just ask the front staff.

FINANCIAL STATEMENT

ALL COPAYS, DEDUCTIBLES, OR CO-INSURANCE IS DUE AT THE TIME OF SERVICE. NO EXCEPTIONS UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

PATIENTS ARE RESPONSIBLE FOR PROVIDING ROSWELL PAIN SPECIALISTS WITH CORRECT INSURANCE INFORMATION. ROSWELL PAIN SPECIALISTS WILL BILL YOUR INSURANCE AS A COURTESY AND IF PAYMENT IS NOT MADE BY YOUR INSURANCE COMPANY WITHIN 90 DAYS OF YOUR DATE OF SERVICE, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL.

UNDERSTAND THAT IF YOUR ACCOUNT IS REFERRED TO A THIRD PARTY FOR COLLECTIONS, YOU WILL BE RESPONSIBLE FOR ANY AND ALL COST RELATED TO THE THIRD PARTY, INCLUDING BUT NOT LIMITED TO, COLLECTIONS AGENCY PERCENTAGE FEES, INTERESTS, COURT COST, AND REASONABLE ATTORNEY FEES.

I understand the above information and am aware at anytime I may request a full copy of the Privacy Notice for Roswell Pain Specialists.

Patient Signature:		Date:	
Print Name:			

IRREVOCABLE ASSIGNMENT, LIEN AND AUTHORIZATION INSURANCE BENEFITS

To Whom It May Concern:

I _____ hereby authorize and direct you, attorney and insurance carrier, to pay directly to Roswell Pain Specialists, such sums as may be due and owing this office for service rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident, Workers' Compensation benefits, or any other insurance benefits obligated to reimburse me from any settlements, judgment or verdict on my behalf as may be necessary to adequately protect Roswell Pain Specialists. I hereby further give lien to said office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as result in injuries or illness for which I have been treated for Roswell Pain Specialists. This is to act as an assignment of my rights and benefits to the extent of the office's service provided.

I understand that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this Assignment, Lien and Authorization do not constitute any consideration for the office await payments, and they may demand payments from me immediately upon rending service at their option.

I authorize the office to release any information pertinent to my case to any insurance carrier or adjuster to facilitate collection under this agreement, Lien and Authorization.

Attorney's Name: _____

Attorney's Signature: _____ Date: _____

Patient Signature: _____ Date: _____

APPOINTMENT DISCLOSURE

Due to the growing nature of our practice, we make sure that scheduled appointments times are honored. If we book an appointment time for you and you miss it, it takes time away from someone who could have potentially scheduled in your place. The same applies to canceling appointments less than 24 hours prior to your appointment time.

Because of this growing problem, we are going to implement a fee to try and minimize on the amount of wasted time and potential space for another patient.

By signing below, I understand the Roswell Pain Specialists, has a missed appointment and cancellation fee in effect. I understand that in the event I miss my appointment or cancel my appointment in less than 24 hours from my appointment time, I will be subject to a $75.00 fee. I understand that is I am charged this fee; it will be due and payable upon my next appointment.

Patient Last Name: _____ Patient First Name: _____

Patient Signature: _____ Date: _____

DISCLOSURE AUTHORIZATION FOR INFORMATION REQUESTS

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), I _____ , hereby authorize the following providers:
_____

To disclose the following protected health information to Roswell Pain Specialists,

- Medical history, including specific progress notes regarding any problems that would impact my consult, office visit, surgery or procedure progress or outcome.
- A list of allergies
- Result of relevant diagnostic or laboratory tests
- Other_____

This protect health information is being used by this institution for Pain Management treatment provided by Rowell Pain Specialists. This authorization shall be in force and effective until _____.

I understand that, as set forth in Roswell Pain Specialists Privacy Notice, I have the right to revoke this authorization, in writing at anytime by sending the written notification to below address.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that Roswell Pain Specialists will not condition my treatment weather I provide authorization for the request use or disclosure.

I understand I have the right to:

- Inspect or copy my protected health information (at a schedule time) to be used or disclosed as permitted under federal law (or state law to the extent the state provides greater access right).
- Refuse to sign this authorization

Patient Signature:		Date:	

HIPPA NOTICE FORM

State of Georgia

Notice of physician's policies and practices to protect the Privacy of your Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

1. **Uses and Disclosures for Treatment, Payment, and Health Care Operations**

   I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

   Protected Health Information (PHI)

   PHI refers to information in your health record that could identify you.

   Treatment, Payment and Health Care Operations

   Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

   Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health h insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

   Health Care Operation are activities that relate to the performance and operation of my practice. Examples of health Care Operation are quality assessment and improvement activities and care coordination.

   Use

   Use applies only to activities within my practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

   Disclosure applies to activities outside of my practice such as releasing, transferring, or providing access to information about you to other parties

2. **Uses and Discloses Requiring Authorization**

   I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written

permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purpose outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information.

You may revoke any authorization at any time, provided each revocation is in writing. You may not revoke an authorization to the extent (1) I have relied on that authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

Uses and Disclosures with Neither Consent for Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse- If I have reasonable cause to believe that a child has been abused, I must report that belief to the appropriate authority.
- Adult and domestic Abuse- if I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report that belief to the appropriate authority.
- Health Oversight Activities Proceedings- If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release information without your written consent or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety- If determine, or pursuant to the standards of my profession should determine, that you present a serious danger of violence to yourself or another, I may disclose information in order to provide protection against such danger for you or the victim.
- Worker's Compensation- I may disclose protected health information regarding you as authorized compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

3. Patient's Right and Psychologist's Duties

Patient's Right

- Right to Request Restrictions- you have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- Right to Receive Confidential Communications by Alternative Means and at alternative Locations- you have the right to request and receive confidential communications of PHI by alternative means at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send bills to another address.)

- Right to Inspect and Copy- You have the right to inspect or obtain a copy (or both) of PHI un my mental health and billing records used to make decision about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- Right to Amend- you have the right to request an amendment of PHI for as long as the Phi is maintained in the record. I may deny your request; I will discuss with you the details of the amendment process.

- Right to an Accounting- You generally has the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- Right to a Paper Copy- You has the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

4. Question and Complaints

If you have questions about the notice, disagree with the decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at my office telephone number 678-736-7680. If you believe that your privacy rights have been violated and wish to file a complaint with me/my office, you may send your written complaint to me at my office address, which is 1300 Upper Hembree Rd, Bldg 100, Suite B, Roswell, GA 30076.

You may also send a written complaint to the Secretary of the U. S. Department of Health and Human Services. I can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you exercising your right to file a complaint.

5. Effective Date, Restrictions, And Changes to Privacy Policy

This notice is effective October 17, 2011. I reserve the right to change the terms of this notice making restrictions or limitations, and to make the new notice provisions on mu website at www.thepainpros.com. A written copy will be provided upon written request.

6. Acknowledgment Statement

I have been informed of the contents of the Georgia Notice Form and the potential uses and disclosures of my protected health information and my right to limit those uses and disclosures. I have also been offered a copy of the form. My signature below is acknowledgment of this.

Patient Signature:		Date:	
Staff Name:		Signature:	

Urine Drug Testing

What is Urine Drug Testing (UDT)?

Urine Drug Testing is a gold standard process that measures the presence or absence of medications and other substances that could interfere with your medications. These tests allow us to properly provide the most accurate healthcare plan for you.

This testing is an essential element of your care plan and allows us to:

- Prescribe the safest and most effective pain medications
- Reduce medication side effects
- Adjust pain medication dosage
- Provide accurate medical treatment based on information attained in new patient evaluations
- Protect patients from possible serious reactions and interference with anesthesia during surgery.
- Nurture mothers and unborn babies by ensuring the absence of toxins.

Roswell Pain Specialists employs a three step process to ensure your accurate and timely results.

1. You will be asked to provide a sample of urine in the cup given to you by our office, using the site restroom facilities. It's important that you do not alter the cup in any way.
2. Our staff will interpret the initial results and will send the sample to an outside laboratory. Our partner, Confirmatrix Laboratory/Castle Medical/Varitas Laboratories, runs tests to confirm the levels of prescribed medications in your system.
3. The physician's office reviews the test results and makes the appropriate adjustments to your treatment plan.

How often will I be tested?

Testing will occur either on a random or scheduled basis as determined by our staff.

Do I pay for this test?

The laboratory will bill your insurer directly for their services. Following their billing, your insurer will send you and Explanation of Benefits (EOB). The EOB is not a bill; it is a statement that shows how the claim for the urine test was processed. Depending on your insurance carrier, you may be responsible for a co-payment, co-insurance and/or deductible. Before making payment on your account, please feel free to consult with USAccuscreen's billing department. WE

welcome the opportunity to address any concerns and answer any questions you may have in relation to your EOB or statement.

I _____ understand that I will be required to provide a urine sample for drug screening each time I am evaluated by Roswell Pain Specialists and it may be referred for further evaluation.

Signature:		Date:	

Lab Solutions
1451 Northside Drive NW
Atlanta, GA 30318
404-343-0788