SOUTHERN TENNESSEE
SPINE & PAIN CENTER

Patient Name: _____

DOB: _____

History of Present Illness

Please select the items in each section below that pertain to your current problems.

Hand Dominance	☐ Right	☐ Left	
Location of Pain	☐ Low Back ☐ Neck ☐ Shoulders ☐ Hips ☐ Elbow	☐ Hands ☐ Wrists ☐ Feet/ankles ☐ Legs ☐ Arms	
Describe your pain	☐ Aching ☐ Burning ☐ Gnawing ☐ Stabbing ☐ Throbbing ☐ Sharp	☐ Dull ☐ Occasional ☐ Frequent ☐ Worsening ☐ Improving ☐ No Change	
Severity of your pain	☐ No Pain ☐ Mild	☐ Moderate ☐ Severe	
Using a sale of 0-10 what is your current pain level?	----------		
What is the duration of your pain?	_____Days _____Weeks	_____Months _____Years	
What makes your pain worse?	☐ Unable to identify ☐ Sitting ☐ Standing ☐ Laying down ☐ Walking ☐ Lifting ☐ Carrying	☐ Twisting ☐ Pushing/Pulling ☐ Grasping/Squeezing ☐ Exercise ☐ Previous Surgery ☐ Computer Use ☐ Changing Clothes ☐ Getting out of bed	☐ Going from sit to stand ☐ Morning ☐ Daytime ☐ Nighttime ☐ Cold weather ☐ Damp weather
Things associated with pain	☐ Weakness ☐ Numbness ☐ Tingling ☐ Swelling ☐ Redness ☐ Warmth	☐ Bruising ☐ Catching/locking ☐ Popping/Clicking ☐ Buckling ☐ Grinding ☐ Instability	☐ Radiation down arms ☐ Radiation down legs ☐ Drainage ☐ Fever ☐ Chills
Timing of your pain?	☐ Unable to identify ☐ Acute ☐ Chronic ☐ Abrupt	☐ Gradual ☐ Morning ☐ Daytime ☐ Nighttime	☐ Recurrent ☐ Rare ☐ Occasional ☐ Intermittent
How did your pain occur?	☐ Unable to identify ☐ Fall ☐ Bending ☐ Lifting	☐ Twisting ☐ Sports injury ☐ Work injury ☐ Car accident	☐ Assault ☐ Overuse ☐ Non-traumatic ☐ Laceration
What helps with your pain?	☐ Nothing helps ☐ Sitting ☐ Standing ☐ Laying Down ☐ Position Change ☐ Heat ☐ Ice	☐ Elevation ☐ Exercise ☐ Stretching ☐ Limited weight bearing ☐ Physical Therapy/Occupational Therapy ☐ Chiropractor	☐ Pain medications ☐ Anti-inflammatories ☐ Spine injections ☐ OTC medications Brace/Sling ☐ Previous surgeries
Please list previous surgeries related to your pain:	_____		
Prior Imaging	☐ None ☐ Nothing in the past year	☐ X-ray ☐ MRI ☐ CT Scan	☐ Bone scan ☐ EMG
Previous injections	☐ None ☐ Did not help	☐ Helped a little ☐ Temporary helped	☐ Significantly helped
Previous Physical Therapy	☐ None ☐ Did not help	☐ Helped a little ☐ Temporarily helped	☐ Significantly helped
Is your pain work related	☐ Yes	☐ No	
Are you currently working?	☐ No ☐ Regular duty	☐ Modified duty ☐ Light duty	

SOUTHERN TENNESSEE
SPINE & PAIN CENTER

Patient Name_____

DOB_____

Review of Systems

Please select items in each section below that pertain to your current problems.

Constitutional	☐ Fever	☐ Weight loss _____ lbs
	☐ Night Sweats	☐ Exercise intolerance
	☐ Weight gain _____lbs	
Cardiovascular	☐ Chest pain	☐ Heart murmur
	☐ Arm pain on exertion	☐ Fast heart rate
	☐ Shortness of breath with walking	☐ Slow heart rate
	☐ Shortness of breath with lying down	☐ Leg swelling
	☐ Palpitations (rapid, strong, or irregular heartbeat)	
Respiratory	☐ Cough	☐ Shortness of breath
	☐ Wheezing	☐ Coughing up blood
Gastrointestinal	☐ Abdominal pain	☐ Frequent diarrhea
	☐ Vomiting	☐ Vomiting blood
	☐ Change in appetite	☐ Constipation
	☐ Black/tarry stools	
Genitourinary	☐ Urinary loss of control	☐ Incomplete emptying
	☐ Difficulty urinating	☐ Pain with urination
	☐ Increased urinary frequency	☐ Pain with intercourse
	☐ Blood in urine	☐ History of kidney stones
Musculoskeletal	☐ Muscle aches	☐ Arm pain
	☐ Muscle weakness	☐ Leg pain
	☐ Joint pain	☐ Shoulder pain
	☐ Back pain	☐ Hip pain
	☐ Neck pain	
Skin	☐ Abnormal moles	☐ Dry skin
	☐ Jaundice (yellow skin)	☐ Growth/lesions
	☐ Rash	☐ Hives
	☐ Itching	
Neurologic	☐ Loss of consciousness	☐ Headaches
	☐ Weakness	☐ Restless legs
	☐ Numbness	☐ Memory loss/lapse
	☐ Seizures	
	☐ Dizziness	
Psychiatric	☐ Depression	☐ Alcohol abuse
	☐ Anxiety	☐ Drug abuse
	☐ Sleep disturbance	☐ Thought of suicide
	☐ Not safe in a relationship	☐ Suicide attempts
Endocrine	☐ Fatigue	☐ Increased hair growth
	☐ Increased thirst	☐ Temperature intolerance
	☐ Hair loss	
Hematologic/Lymphatic	☐ Swollen glands	☐ Easy bleeding
	☐ Easy bruising	

SOUTHERN TENNESSEE
SPINE & PAIN CENTER

Policies and Procedures

Thank you for choosing Southern Tennessee Spine and Pain for treating your pain. Our goal is to help you improve your quality of life and level of function. To accomplish this, it is imperative that you work with your physician and follow the treatment plan that he/she has designed for you. In our efforts to provide the highest level of medical care to our patients, it is important for you to be aware of the guidelines of our practice and to adhere to the policies that are set forth:

- Information Updates- Please keep us informed of any changes to your insurance, name, address and phone number.
- Insurance Cards- Please always bring all Current insurance cards. We are eager to help you receive your maximum allowable benefits, but must have current information in order to do this. You may not be seen if this information is not current.
- Medications- ALWAYS bring your medicine bottles with medications (prescribed by our clinic) to every appointment. *I give permission to this office to download my medication history from my pharmacies into my electronic chart.*
- Medical Changes- Make sure to report any tests or hospitalizations since your last appointment.
- Co-Pays- All copays are due and expected at the time of your appointment. We accept cash, check, or credit card.
- Financial Policy- As a service to you, we will gladly submit your claims to your insurance company. However, you are financially responsible for all changes. "Along with your copay, we require payment for any expected deductible or co-insurance." If you do not have insurance you are expected to pay in full at time of service.
    - As the patient though we may help you are responsible to obtain any pre-cert, authorization, or referral necessary for your appointment.
    - ***If your insurance denies charges, you are responsible to call them for any explanation.***
    - We expect payment of all services within 60 days. This may require you to pay your account in full if your insurance company fails to pay.
    - *Payment options are available by speaking with our billing staff.*
    - There is a $25 charge for all checks returned to us for insufficient funds.
    - Delinquent accounts of greater than 90 days will result in your discharge from this facility. Up to a 50% collection fee can be added to your account, and will be referred to our collection agency. It will also be reported to the credit bureau.
- Appointment time- All patients will be seen in order by appointment time. Please arrive 30 minutes prior to your appointment. If you arrive late your appointment will be rescheduled.
- Cancellations- Out of consideration for others in pain, please give 24 hour notice if you cannot keep your appointment to allow time to be used by another patient that is in pain. Multiple missed or cancelled appointments will be considered non-compliant and may result in discharge from the clinic. Due to the length of the reserved time slot, if you miss scheduled therapeutic injection appointments without giving 24 hour notice you may not have these options available to you in the future.
- Treatment- It is your obligation to tell your provider the truth about the nature and duration of your symptoms and medical history. You are also obligated to follow your provider's instruction concerning diet, medication, exercise, personal habits, and follow up appointments.
- Drug Tests- Random laboratory tests will be performed to make your medication regiment as safe as possible. By signing this form, you agree to submit to random tests, as is required by your Medications Management Contract. You will be responsible for the charges incurred for these tests. Any illegal substances (including marijuana, cocaine, etc.) or controlled substances not prescribed by this office detected in these test may result in termination from this practice.
- Prescription Refill- All prescriptions must be obtained by appointment. No refills or new prescriptions will be phoned in.
- Telephone Calls- All telephone calls will be returned within two business days. If your condition is such that you feel like you can't wait that length of time, please go to the nearest emergency room.
- Medical Record's Release- Medical records will be released only with the patients signed consent. There will be a charge for reproduction of medical records or completing FMLA or other papers. Request will be completed within 10 business days and payment will be due at the time of pickup. If records are to be mailed payment must be made in advance.
- PHI- Southern Tennessee Spine and Pain uses and discloses patient health information to provide treatment, to obtain payment, and for health care operations, including administrative purposes. By signing below you consent to such use and disclosure of your health information.

By singing below, I understand and agree to abide by the above office policies.

Signature: _____ Date: _____

SOUTHERN TENNESSEE
SPINE & PAIN CENTER

Name_____ Date_____

This questionnaire has been designed to give your physician information as to how your pain has affected your ability to manage in everyday life. Please answer every question by placing a mark in *ONE* box, in each section that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but please only mark the box which most closely describes your current condition.

Section 1 – Pain Intensity ☐ 0. I can tolerate the pain without having to use pain medication. ☐ 1. Pain is bad, but I can manage without taking pain medication. ☐ 2. Pain medication provides me with complete relief from pain. ☐ 3. Pain medication provides me with moderate relief from pain. ☐ 4. Pain medication provides me with very little relief from pain. ☐ 5. Pain medication has no effect on the pain.	Section 6 – Standing ☐ 0. I can stand as long as I want without increased pain. ☐ 1. I can stand as long as I want, but it increases my pain. ☐ 2. Pain prevents me from standing more than 1 hour. ☐ 3. Pain prevents me from standing more than 30 minutes. ☐ 4. Pain prevents me from standing more than 10 minutes. ☐ 5. Pain prevents me from standing at all.
Section 2 – Personal Care (washing, dressing, etc.) ☐ 0. I can take care of myself normally without causing increased pain. ☐ 1. I can take care of self normally, but it increases my pain. ☐ 2. It is painful to take care of myself and I am slow and careful. ☐ 3. I need help, but I am able to manage most of my personal care. ☐ 4. I need help every day in most aspects of self-care. ☐ 5. I do not get dressed, wash with difficulty, and stay in bed.	Section 7 - Sleeping ☐ 0. Pain does not prevent me from sleeping well. ☐ 1. I can sleep well only by using pain medication. ☐ 2. Even when I take pain medication, I sleep less than 6 hours. ☐ 3. Even when I take pain medication, I sleep less than 4 hours. ☐ 4. Even when I take pain medication, I sleep less than 2 hours. ☐ 5. Pain prevents me from sleeping at all.
Section 3 – Lifting ☐ 0. I can lift heavy weights without increased pain. ☐ 1. I can lift heavy weights, but it causes increased pain. ☐ 2. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table. ☐ 3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. ☐ 4. I can only lift very light weights. ☐ 5. I cannot lift or carry anything at all.	Section 8 – Social Life ☐ 0. My social life is normal and does not increase my pain. ☐ 1. My social life is normal, but it increases the level of my pain. ☐ 2. Pain prevents me from participating in more energetic activities (e.g., sports, dancing, etc.). ☐ 3. Pain prevents me from going out very often. ☐ 4. Pain has restricted my social life to my home. ☐ 5. I have hardly any social life because of pain.
Section 4 - Walking ☐ 0. Pain does not prevent me walking any distance. ☐ 1. Pain prevents me walking more than 1 mile. ☐ 2. Pain prevents me walking more than 1/2 mile. ☐ 3. Pain prevents me walking more than 1/4 mile. ☐ 4. I can only walk with crutches or a cane. ☐ 5. I am in bed most of the time and have to crawl to the toilet.	Section 9 - Travel ☐ 0. I can travel anywhere without increased pain. ☐ 1. I can travel anywhere, but it increases my pain. ☐ 2. My pain restricts my travel over 2 hours. ☐ 3. My pain restricts my travel over 1 hour. ☐ 4. My pain restricts my travel to short necessary journeys under 1/2 hour. ☐ 5. My pain prevents all travel except for visits to the physician/therapist or hospital.
Section 5 – Sitting ☐ 0. I can sit in any chair as long as I like. ☐ 1. I can only sit in my favorite chair as long as I like. ☐ 2. Pain prevents me from sitting more than 1 hour. ☐ 3. Pain prevents me from sitting more than 1/2 hour. ☐ 4. Pain prevents me from sitting more than 10 minutes. ☐ 5. Pain prevents me from sitting at all.	Section 10 – Employment/Homemaking ☐ 0. My normal homemaking/job activities do not cause pain. ☐ 1. My normal homemaking/job activities increase my pain, but I can still perform all that is required of me. ☐ 2. I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming). ☐ 3. Pain prevents me from doing anything but light duties. ☐ 4. Pain prevents me from doing even light duties. ☐ 5. Pain prevents me from performing any job or homemaking chores

_____+_____1x100=_____% of Maximum

(Patients Total Points) (No. of sections Completed)

SOUTHERN TENNESSEE
SPINE & PAIN CENTER

Patient Name: _____ Date: _____

As you know, there are several legal, medical, ethical and social issues associated with pain medicine. Because pain is subjective and cannot be proven, the medical community has developed several questionnaires and forms to help evaluate pain.

OPIOID RISK TOOL:

Many patients are rightfully concerned about the risk of addiction to their pain medications. The risk of addiction actually is quite low when the medications are used properly for pain.

Sometimes a patient already has an addition disorder. This does not mean that the patient is not deserving of pain control, but it does mean that we need to use extra caution so as to provide the pain control without worsening the addictive disorder. This questionnaire was developed for this purpose and can help use determine your risk of addiction with medications.

Please complete the ORT below honestly. After filling out this form we can then discuss your level of risk of becoming addicted or having an addictive disorder. This questionnaire is not meant to be a judgment of you as a human being.

Factor		**Score**			
		Female		Male	
		YES	NO	YES	NO
1. Family History of Substance Abuse	Alcohol				
	Illegal Drugs				
	Prescription Drugs				
2. Personal History of Substance Abuse	Alcohol				
	Illegal Drugs				
	Prescription Drugs				
3. Age (If between 16 to 45)					
4. History of Preadolescent sexual abuse?					
5. Do you have a history of any of the following conditions?	ADD, OCD, Bipolar, Schizophrenia				
	Depression				
TOTAL Score					
Low Score = 0 to 3					
Moderate Score = 4 to 7					
High Score = ≥ 8					

SOUTHERN TENNESSEE
SPINE & PAIN CENTER

Controlled Substance Patient Agreement

Patient Name: _____

I understand that this agreement between myself and Southern Tennessee Spine and Pain Center is intended to clarify the manner in which chronic (long-term) controlled substances will be used to manage my chronic pain. I understand that there are side effects to this therapy these include, but are not limited to, allergic reactions, depression, sedation, decreased mental ability, itching, difficulty in urinating, nausea and vomiting, loss of energy, decreased balance and falling, constipation, decreased sexual desire and function, and potential for overdose and death. Care should be taken when operating machinery or driving a car while taking these medications. When controlled substances are used long-term, some particular concerns include the development of physical dependence and addiction. I understand these risks and have had my questions answered by my physician. I understand that my physician will prescribe controlled substances only if the following rules are adhered to:

- All controlled pain medication prescriptions must be obtained by **Southern Tennessee Spine and Pain Center.** If a new condition develops, such as trauma or surgery, I will notify that physician that I am already taking pain medications. The physician caring for that problem may or may not prescribe narcotics for the increase in pain that may be expected. I will notify Southern Tennessee Spine and Pain Center within 48-hours of me receiving a narcotic or any other controlled substance from any other physician or other licensed medical provider. For females only: If I become pregnant while taking this medicine, I will immediately inform my obstetrician and obtain counseling on risks to the baby.
- I will submit urine and/or blood on request for testing at any time without prior notification to determine the use of non-prescribed drugs and medications and confirm the use of prescribes medications. I will submit pill counts without notice as per physician's request. I will pay any portion of the costs associated with urine and blood testing that is not covered by my insurance.
- All requests for refills must be made by contacting Southern Tennessee Spine and Pain Center during business hours at least 3-bussiness days in advance of the anticipated need for the refill. All prescriptions must be filled at the same pharmacy, which is authorized to release a record of my medications to this office upon request. A copy of this agreement will be sent to my pharmacy.

Pharmacy Name/ Location: _____

Controlled Substance Patient Agreement

Continued…

- The daily dose may not be changed without Southern Tennessee Spine and Pain Center physician's consent. This includes either increasing the daily dose or breaking tablets.
- Prescription refills will not be given prior to the planned refill date determined by the dose and quantity prescribed. I will accept generic medications.
- Accidental destruction, loss of medications or prescriptions will not be a reason to refill medications or rewrite prescriptions early. I will safeguard my controlled substance medications from use by family members, children or other unauthorized persons.
- You may be referred to an appropriate specialist to evaluate your physical condition.
- You may be asked to have an evaluation by either a psychiatrist or psychologist to help manage your medication needs.
- If your physician determines that you are not a good candidate to continue with the medication, you may be referred to a detoxification program or evaluation by a pain management center.
- These medications may be discontinued or adjusted at your physician's discretion.
- I understand that it is my physician's policy that all appointments must be kept or cancelled at least 2-bussiness days in advance. I understand that the original bottle of each prescribed controlled substance medication must be brought to every visit. I understand that I am responsible for meeting the terms of this agreement and that failure to do so will/may result in my discharge as a patient of Southern Tennessee Spine and Pain Center. Grounds for dismissal from Southern Tennessee Spine and Pain Center include, but are not limited to: Evidence of recreational drug use, of drug diversion, of alternating scripts (this may result in criminal prosecution), of obtaining controlled substance prescriptions from other doctors without notifying this office, abusive language towards staff, development of progressive tolerance, use of alcohol or intoxicants, engagement in criminal activities, etc.

*** Chronic controlled substance therapy for patients who do not suffer from cancer pain is a controversial issue.**

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

SOUTHERN TENNESSEE
SPINE & PAIN CENTER

Controlled Substances Informed Consent

Please read the information below carefully and ask your provider if you have any questions relating to the medication prescribed to you.

Using Controlled Medications to Treat Pain:

- **A.** These medications are used to treat moderate-to-severe pain of any type, and to treat anxiety and stress associated with moderate-to-severe pain.
- **B.** These medications are best understood as potentially effective tools that can help reduce pain, improve function, and improve quality of life.
- **C.** Using these medications requires that both the physician and patient work together in a responsible way to ensure the best outcome, lowest side effects, and least complications.

How Do Opioids Work?

- **A.** Opioid medications work at the injury site, the spinal cord, and the brain.
- **B.** They dampen pain, but do not treat the underlying injury.
- **C.** They may help to prevent acute pain from becoming persistent chronic pain.
- **D.** These medications may work differently on different people because of a number of factors.
- **E.** Side effects and complications will also individually vary.

How Do Benzodiazepines Work?

- **A.** The Benzodiazepines are a class of drugs with varying properties, which act by slowing down the central nervous system.
- **B.** Benzodiazepines are useful in treating anxiety, insomnia, agitation, seizures, and muscle spasms. While Benzodiazepines do not treat acute or chronic pain, they are taken by patients with pain for other issues (such as anxiety or muscle spasms).
- **C.** These medications may work differently on different people because of a number of factors.
- **D.** Side effects and complications will also individually vary.

What To Expect When You Take Controlled Medications for Pain and Related Conditions:

- **A.** Pain reduction (30-40%)
- **B.** Reduction of anxiety and stressed caused by pain
- **C.** Side effects

What Should Not Be Expected From Treatment with Controlled Medications?

- **A.** Cure of the underlying injury
- **B.** Total elimination of pain, anxiety, and stress
- **C.** Loss of ability to feel other physical pain

Negative Effects of Controlled Medications Vary in Different People:

1. **Opioid Side Effects:**
   - **A.** Common effects include: Constipation, dry mouth, sweating, nausea, drowsiness, euphoria, and forgetfulness, difficulty urinating, and itching.
   - **B.** Uncommon effects include: Confusion, hallucinations, shortness of breath, depression, lack of motivation.
2. **Benzodiazepines Side Effects:**
   - **A.** The most common side effects include: Clumsiness or unsteadiness, dizziness or lightheadedness and drowsiness, slurred speech.
   - **B.** Less common side effects include: Anxiety; confusion (may be more common in the elderly); fast, pounding, or irregular heartbeat; mental depression; abdominal or stomach cramps or pain; blurred vision or other changes in vision; changes in sexual desire ability; constipation; diarrhea; dryness of mouth or increased thirst; false sense of wellbeing; headache; increased bronchial secretions or watering of mouth; muscle spasm; nausea or vomiting; problems with urination; trembling or shaking; unusual tiredness or weakness.
3. **Physical Dependency:**
   - **A.** Opioid medications will cause a physical dependency marked by abstinence syndrome when they are stopped abruptly. If these medications are stopped or rapidly decreased the patient will experience chills, goose bumps, profuse sweating, increased pain, irritability, anxiety, agitation, and diarrhea. The medicines will not cause these symptoms if taken as prescribed and any decision to stop these medications should be done under the supervision of your physician in a slow downward taper.

B. Benzodiazepines may be habit-forming (causing mental or physical dependence), especially when taken for a long time or in high doses.

C. Benzodiazepines dependency results in a strong desire or need to continue taking the medicine; a need to increase the dose to receive the effects of the medicine. Withdrawal effects occurring; for example, irritability, nervousness, trouble in sleeping, abdominal or stomach cramps, trembling or shaking.

4. **Addiction:**
   A. Is a psychological condition of use of a substance despite self-harm. Between six and ten percent of the population of the United States have problems with Substance Use Disorder and addiction. Controlled medications are likely to activate addictive behavior in this group or people.
5. **Diversion:**
   A. It is illegal to share your controlled medications with other people. It is illegal to provide false information to a prescriber in an attempt to obtain controlled medication. It is illegal to doctor shop, or visit multiple doctors in attempt to obtain controlled medications. Federal and state laws exist to address diversion problems. It is critical that you safeguard your controlled medications and use them only as prescribed by your doctor.
6. **Driving**
   A. Studies of patients with chronic pain demonstrate improved driving skills when taking certain controlled medications, but individuals may have problems driving and need to realistically assess their own skills, as well as listen to others who drive with them to determine if they should be driving while taking these medications. You should consult the State Department of Transportation if you have questions about driving and taking controlled medications. This is especially important if your work involves driving, making important decisions that affect others, etc. We cannot certify that you are safe to drive while taking controlled substances.

Common Sense Rules for Using Controlled Medications:

A. Follow your doctor's recommendations.
B. Do not take more or less pills than prescribed without discussing this first with your physician and receiving permission to do so.
C. Do not share medications with family or friends.
D. Do not take medications from family or friends.
E. Do not stop these medications abruptly. Dose reductions need to be discussed and cleared by your physician. This is important no matter which controlled medication you take.
F. Do not sell medications.
G. Do not take medications in any manner other than prescribed. For example, do not chew or inject your medications.
H. Keep all medications out of reach of children.
I. Do not leave your prescriptions or controlled medications lying around unprotected for others to steal and abuse them.
J. Do not operate a motor vehicle if you feel mentally impaired using controlled medications. You are responsible for exhibiting good judgment in your daily affairs, including your use of controlled medications.
K. Alcohol use should be curtailed when using controlled medications.

Continued Use of Controlled Medication is based on your physician's judgment and a determination of whether the benefits to you of using controlled medications outweigh the risks of using them. Your physician may discontinue treating you at his or her discretion. Your physician may require a consultation with an addiction specialist. Your physician may require more frequent visits. We believe in treating your pain and we recognize the value of controlled medications in this process. When used properly, controlled medications can help restore comfort, function, and quality of life. However, as stated above, controlled medications may also have serious side effects and are highly controlled because of their potential for misuse and abuse. It is important to work with your physician and communicate openly and honestly with him or her about your pain control needs. By doing so, medications can be used safely and successfully. By your signature below, you are acknowledging that you have read and reviewed these matters with your physician and that you have sufficient information to make a decision to use the controlled medications prescribed. You should NOT sign this form if you do not believe you have enough information to make an informed decision about your use of controlled medications and how they fit in to your pain management treatment plan.

Patient Name: _____ Physician Signature: _____

Patient Signature: _____ Date: _____

SOUTHERN TENNESSEE SPINE & PAIN CENTER

81 Memorial Drive

Winchester, TN 37398

Phone: 931-962-8012

Fax: 931-968-1968

I hereby authorize _____ and its providers, employees, and agents to release or disclose below named person or organization my medical records.

Release records to: Southern Tennessee Spine and Pain Center

Patient Name: _____

Date of Birth: _____ SS Number: _____

Records Needed: _____ Copy of all records

_____ Copy of x-rays, MRI, CT, Labs, Path reports

_____ Copy of operative reports, consultation notes

_____ Other _____

I understand that I may revoke the authorization at any time prior to the expiration date or event but that my revocation will not have any effect on action taken by the above named healthcare provider or it's provider's, employees, or agents before they received my revocation. Should I desire to revoke the authorization, I must send a written notice to the named healthcare provider.

I understand that I am not required to sign this authorization. The above named healthcare provider will not condition treatment, payment, enrollment, or eligibility for benefits on whether I provide this authorization.

I understand that my records may be subject to disclosure by the recipient and may no longer be protected by the federal privacy regulations. I understand that this authorization does not limit the above named healthcare provider or its provider's employees, or agent's ability to use or disclose my information for treatment payment or healthcare operations or as otherwise permitted by law.

I understand that a photo copy of this authorization is to be considered as the original.

Patient or Authorized Representative's Signature: _____

Date: _____ Relationship to Patient: _____