# Patient & Insurance Information

**Name:** _____ Male _____ Female _____

**Social Security #** _____ **Date of Birth** _____

Home# (  ) _____ Work# (  ) _____ Cell# (  ) _____

Home Address (***NO P.O. BOXES)*** _____

Mailing Address (*If different than above*) _____

Employer Name & Address ***(NO P.O. BOXES)***_____

**Primary Insurance**_____ **Subscriber's Name**_____

**SS#** _____ **DOB** _____

**Secondary Insurance** _____ **Subscriber's Name** _____
**SS#** _____ **DOB**_____

**Emergency Contacts**: List persons who may be contacted in case of emergency.

**Name** _____ Address ***(NO P.O. BOXES)***_____

Home# (  ) _____ Work# (  ) _____ Cell# (  ) _____

**Name**_____Address (**NO P.O. BOXES**)_____

Home# (  )_____ Work# (  )_____Cell# (  )_____

**Spouse's Name:** _____ DOB _____

**Social Security #** _____**Employer & Address**_____

Home# (  ) _____ Work# (  ) _____ Cell# (  ) _____

**Person Responsible for this Account *(if other than patient)*:** _____

**Social Security #** _____ **Date of Birth** _____

Home Address (***NO P.O. BOXES)*** _____

Home# (  ) _____ Work# (  ) _____ Cell# (  ) _____

Relationship to patient _____

**ASSIGNMENT AND RELEASE**

I, the undersigned, certify that I (or my dependant(s)) have insurance with the above indicated company(ies) and assign directly to The Center for Physical Medicine and Pain Management all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize The Center for Physical Medicine and Pain Management to release all information necessary to secure the payment of services. I authorize the release of past medical payment history from credit reporting agencies and I authorize the use of this signature on all insurance claims.

**AGREEMENT TO PAY**

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

**EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE**

You agree, in order for us to service your account or to collect monies you may owe,
(CPMPM) and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

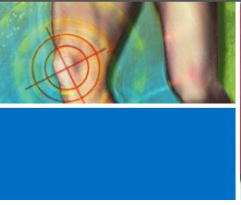
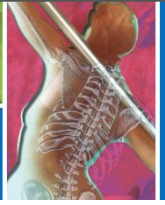
I/We have read this disclosure and agree that (CPMPM), its employees and/or agents may contact me/us as described above.

_____ _____

Patient Signature Date

_____ _____ _____

Responsible Person's Signature (if other than patient) Relationship to Patient Date

THE CENTER *for* PHYSICAL
MEDICINE & PAIN MANAGEMENT
RACHELLE JANUSH, D.O.

2227 Taylor Road
Montgomery, Alabama 36117
334-260-8988 *office*
334-260-8225 *fax*

# TREATMENT AGREEMENT WITH INFORMED CONSENT

Controlled substances can be useful, but they have a high potential for misuse and abuse. The local, state, and federal governments closely control and monitor these medications. They are intended to help relieve pain, to improve function and ability to work, not simply "to feel good." Below is our strict policy regarding the use of prescribed medications.

I, the undersigned, agree to the following terms and conditions regarding any prescriptions written by Dr. Janush and/or CPMPM and accept the consequences of violating this agreement. Should any of the following policies be violated, I understand that all of my treating physicians and/or treatment centers, facilities, and the proper authorities may be contacted and informed.

1. Act 2013-258, HB152: According to the Act, it makes it a crime to deceptively obtain a controlled substance from Dr. Janush by intentionally withholding information that you received a similar prescription for a controlled substance from another physician. The act provides that a violation of this sort can lead to a Class "C" felony. ***"Dr. Shopping"*** may lead to a Class "C" felony that can lead to no less than one year and one day and no more than 10 years in jail.

2. I understand that the main treatment goal is to improve my ability to function and/or work. Possible prescriptions of controlled medications represent only a part of CPMPM's multidisciplinary approach to the diagnosis and treatment of pain, thus participation in other treatments is required. ***I agree to help myself by improving my health habits****: exercise, weight control, and non-use of tobacco, alcohol, and recreational drugs. I understand that only through a healthier lifestyle can I hope to have the most successful outcome to my treatment.*

3. Patient care at CPMPM is precipitated on participating in periodic urinalysis for compliance with medications in agreement with the Drug Enforcement Agency standards at Dr. Janush's determination. I have the choice to participate in the current lab established at CPMPM verses other acceptable certified laboratories. If I choose not to participate in the urinalysis I understand that Dr. Janush can cease to treat me.

4. I will participate in periodic pill counts that are conducted at CPM&PM. I must report in a specific time frame allotted with all bottles of medications and all remaining, unfilled written prescriptions for opiates. Failure to do so will constitute termination of treatment by Dr. Janush.

5. I am personally responsible for the proper custody, safeguarding and use of medications and/or written controlled substances. WITHOUT EXCEPTION no controlled substance medication will be prescribed to replace lost, stolen, destroyed, damaged, misplaced and/or written prescriptions. Medication is intended for use by me, the prescribed patient, in the manner dosage and interval. Any intentional redistribution or alteration of the prescription constitutes criminal intent and will constitute a violation of the agreement. All confidentiality in regards to medication prescriptions is waived for legal authorities. A handout of safe usage and storage of controlled substances is available and you are warned to review and use.

6. Several types of medications including opiates and controlled medicines as well as anti-seizure medications may cause birth defects in an unborn fetus. Female patients of childbearing age are warned to use strict birth control options to prevent pregnancy while taking any medication prescribed by Dr. Janush. If I am a female patient and I am pregnant, I must obtain clearance from my OB/GYN for any injectable medication or continuation of any other current medications. I must inform Dr. Janush verbally and in writing of any possibility of pregnancy prior to injectable medication and/or new medication prescriptions are accepted.

7. Prescriptions, refills, and/or changes:
   a. I will disclose the name and telephone contact numbers of all doctors and pharmacies used including mail order and internet.
   b. Medication prescriptions, refills, and changes will be made only during Dr. Janush's regular office hours, in person, during a scheduled office visit.
   c. Refills **will not be made** at night, on holidays, or weekends, nor by a covering physician.
   d. Refills **will not be made** as an emergency if, "I ran out early".
   e. An administrative fee is levied for every prescription outside of office visit including but not limited to faxes, calls to pharmacy, and renewals. This is not covered by your insurance.
   f. Should circumstances require Dr. Janush to be contacted outside of regular office hours for telephone medical attention I will be responsible for minimum after hours call fee of $100 which is not covered by insurance.
   g. No medication discussion will occur in the hallway, at the front window, lobby, etc., regarding medications, refills, and/or changes.
   h. If you should change pharmacies for any reason, such as availability of drugs, you will inform us immediatly.

2227 Taylor Road
Montgomery, Alabama 36117
334-260-8988 office
334-260-8225 fax

8. **I WILL NOT REQUEST OR ACCEPT** controlled medications from any other physician or individual while I am receiving any controlled medications from Dr. Janush. Doing so may endanger my life and cause death. The only exception is if controlled medication is prescribed while I am admitted to a hospital or emergency room. Should I accept/ receive any controlled substance while admitted to a hospital or seen at an emergency room I will contact Dr. Janush's office within 48-hours of being discharged from either facility. **IT IS MY DUTY TO DISCLOSE ALL MEDICATIONS, NEW OR CHRONIC, AT EACH VISIT TO ALL OF MY PHYSICIANS**. I am to keep a list on my person of ALL current medications to present for emergencies or to my physicians for review.

9. I understand and agree to not use alcohol with controlled substances or opiates. I will not take medications that were stopped nor prescribed to me, nor will I use any recreational "street drugs." My treatment at CPMPM, is dependent upon not using these substances. These substances can be fatal in combination and I could die.

10. Stopping any opioid or controlled medication must be first discussed with Dr. Janush. Sudden discontinuation or "Cold turkey" of medication may cause withdrawal symptoms, seizure activity, and/or death.

11. If I feel mentally foggy or tired or drowsy, I will not drive, operate heavy equipment, nor serve in any capacity related to public safety and any changes to my medication dosages or timing can cause the feeling of drowsiness. Patient is to check with The State of Alabama for driving restrictions.

12. If your legs are weak you will not drive. You will not drive if drowsy. If you are prescribed a new medication you will not drive for (7) days or until you are completely stable.

13. Be aware that medication can affect your sexuality and sex drive.

14. I will bring the original containers of each medication prescribed by Dr. Janush at each visit, even if there is no medication remaining. I may be requested by phone to come into the clinic for a periodic pill count. This is mandatory and is not optional. Periodic urine or blood drug screening may be requested at any time and will be the patient's financial responsibility. Failure to participate will constitute a violation of this agreement.

15. I authorize Dr. Janush, CPMPM, its staff and agents during my treatment to inquire at any pharmacy, medical office, treatment centers, and/or emergency facilities in regards to any medications prescribed to me at any time. I agree to waive any applicable privilege, right of privacy, or confidentially with respect to these authorizations.

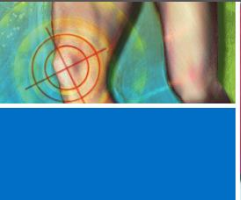
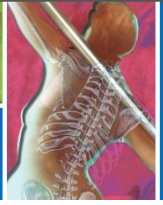
16. Strict adherence to controlled substance, dose milligram and timing schedule is required. I am responsible for taking my medications as prescribed and <u>will not alter the dosage or interval or the form in which it was made,</u> without the consent of the prescribing physician. If the medication is not optimal I agree to notify your office or report it at the next visit. If I have an adverse reaction to a medication I am to report it immediately to the prescribing physician so that he/she can give appropriate care. I am responsible to keep track of the amount of medication remaining and when I am due for my next prescription.

17. I understand that if I violate any of the above conditions, my treatment with Dr. Janush may be ended immediately. If the violation involves obtaining controlled substances from another individual or medical center, as described above, this agreement will be forwarded to the prescribing physician, medical facilities, and proper authorities.

18. The DEA requirements are that Dr. Janush is obligated to take reasonable measures to prevent diversion and abuse. In this medical clinic we utilize periodic urine analysis, medication counts and State of Alabama Medication Query List. Your care at The Center for Physical Medicine and Pain Management is dependent upon your participation.

19. **DISCLOSURE**

Dr Janush does not have a degree in addiction medicine and by the state law of Alabama Dr Janush cannot maintain or treat addiction. I have been fully warned by Dr. Janush and/or her staff regarding possible psychological dependence (addiction) of controlled substances and physical dependence. Some people may develop a tolerance, which is the need to increase the dose of the medication to achieve the same effect of pain control. I understand that I may become physically dependent on the medication. This may occur if

THE CENTER *for* PHYSICAL
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RACHELLE JANUSH, D.O.

2227 Taylor Road
Montgomery, Alabama 36117
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334-260-8225 *fax*

I am on the medication for several weeks. When the medication is stopped, I must also do it slowly and only under medical supervision or I may have withdrawal symptoms, seizure activity and/or death.

This agreement shall supersede any other agreements entered into by me the patient in whole or in part. I further agree to indemnify, defend and hold harmless Dr Janush, The Center for Physical Medicine and Pain Management, its staff, and/or its agents from any claims made as a result of this agreement.

_____ _____/_____/_____

**Patient's Signature** **Date**

# The Center for
# Physical Medicine & Pain Management, P.C.
## *Rachelle Janush, D.O.*

2227 Taylor Road ♦ Montgomery, AL 36117
Office: 334-260-8988 ♦ fax: 334-260-8225


## OFFICE POLICIES

### 1. INSURANCE

Our office is a participating provider with **AETNA, BLUE CROSS & BLUE SHIELD, MEDICARE, AND UNITED HEALTHCARE** only and does not accept patients without insurance. Charges for services rendered will be submitted to your insurance company in accordance with contractual agreements. Our office only performs procedures that are medically necessary. A patient is responsible for all charges not covered by their insurance company (ies).

Charges that are not paid or denied within 60-days of filing will become the patient's responsibility and will be due immediately upon request or balanced billed. Upon request, patients are given copies of the charges so they can file claims with their insurance carrier.

If you are covered by an insurance carrier other than ones listed above, contact our office and speak with our billing department. Charges with non-contractual insurance carriers may be filed only as a courtesy. A patient who fails to disclose coverage with a non-contractual insurance carrier will be responsible for all charges incurred and/or claims denied. A patient not making billing arrangements prior to services being rendered will be responsible for 100% of the charges.

A patient who has changes in address or insurance must notify this office prior to services being rendered. A patient failing to notify this office before services are rendered may cause his/her claims to be rejected or denied. Therefore, any claims rejected or denied for these reasons will be the patient's responsibility and an administrative fee for each claim rejected or denied may also apply.

### 2. CO-PAYMENTS AND ACCOUNT BALANCES

Insurance carriers mandate that co-payments and deductibles are paid at the time of service. All payments received at the time of service or by mail will be applied to outstanding balances first. Co-payments, deductibles, and account balances not made at the time of service are subject to a $15 administrative fee.

A patient with account balances over 30 days past due will be reported to the credit bureau in accordance with the Fair Credit Reporting Act. A patient with account balances will be responsible for all administrative costs associated with collecting account balances. These costs include, but are not limited to, certified mailing fees and billing statement fees. A patient is encouraged to submit any balances due upon receiving their explanation of benefits from their insurance carrier(s) to avoid such fees.

### 3. SPECIAL REQUESTS

Special requests including, but not limited to, insurance forms, disability forms, FMLA letters, and others are NOT covered by insurance and are a patient responsibility. An administrative fee will be charged to the requesting party for each special request. Prepayment is required to process each special request and is processed on a first come, first served basis.

Requests will be processed as time allows in the doctor's daily schedule and can take up to eight weeks. Remember, patient care is her primary focus. While every effort is made to process these requests within 30-days, no timely guarantee is given for the amount of time to process these requests.

### 4. CELL PHONES, VIDEO RECORDERS, CAMERAS, AND OTHER DEVICES

Electronic devices including, but not limited to, cell phones, video recorders, cameras, or any other recording devices are **NOT** permitted in the examination areas. A patient not turning off electronic devices can interrupt medical treatment startling the physician, this is unsafe and can cause a fatal complication. A patient may be rescheduled for such instances and will be responsible for co-pays or cancelled appointment fees regardless if the examination was completed.

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**5. ATTORNEYS**

A patient who presents legal documents such as subpoenas to appear in court to The CPM & PM will be the responsibility of the attorney or the legal entity. Requests to produce true copies of patient's medical records will be the responsibility of the attorney or legal entity. Pre-payment is required prior to performing any such services.

If the patient's attorney or entity retained does not agree to pay for these services or, The CPM & PM incurs any legal costs as a result of such requests, the patient will be responsible for the sum total of all such costs associated with the request. This agreement will supersede any other agreements entered into by the patient and his/her or her attorney or entity in whole or in part.

**6. WEAPONS**

Weapons including, but not limited to, guns or knives are NOT permitted in this facility. All active law enforcement officers who are carrying his or her weapon while off duty must inform the receptionist of his or her status prior to each visit. A patient violating this policy is subject to immediate termination of care.

**7. EXPRESS PRIOR CONSENT TO CONTACT PATIENT BY CELL PHONE**

I, the undersigned, give The Center for Physical Medicine and Pain Management, its employees and/or agents "express prior consent" to contact me at any/all telephone numbers, including cell phone numbers (by telephone call or text message), for the purpose of treatment, insurance, or payment.

**8. CANCELLATION OF APPOINTMENTS**

We at The Center for Physical Medicine & Pain Management do NOT double book patients for examination and treatment. Therefore we have a strict cancellation policy. Our offices are open Monday – Thursday from 8:30am – 4:30pm. Notify our office **forty-eight (48)** hours (2-busniess days) in advance if you are unable to keep your scheduled appointment. A patient not canceling appointments **forty-eight (48)** hours (2-business days) before appointment date is subject to a $35 office visit charge for examinations and $75 for diagnostic or procedural visits. This charge will NOT be billed to your insurance company. This fee is the patient's responsibility and is due at billing or upon to the next scheduled appointment, whichever occurs first. **Patients arriving more than 15 minutes late may have their appointment cancelled.**

**9. TERMINATION**

Dr Janush has express medical legal right to discharge any patient for including but not limited to verbal abuse, hostility or failure to comply with medical recommendations or business policies, in part or in total.

**10. DISCLOSURES**

I, the undersigned, have read and understand the above-mentioned policies and my signature below indicates that this agreement shall supersede any other agreements entered into by me, the patient, in whole or in part. I further state that I am covered with an insurance company listed above. I understand that if I fail to disclose coverage with any non-contractual insurance carrier(s) that I will be responsible for any charges incurred and/or claims denied for services rendered. I further agree to indemnify, defend and hold harmless The Center for Physical Medicine and Pain Management, its staff, and/or its agents from any claims made as a result of this agreement.

_____ _____/_____/_____

**Patient Signature** **Date**

**The Center for**
**Physical Medicine & Pain Management, P.C.**
***Rachelle Janush, D.O.***
2227 Taylor Road ♦ Montgomery, AL 36117
Office: 334-260-8988 ♦ fax: 334-260-8225

# MEDICAL DISCLOSURE AUTHORIZATION

Choose section 1 or 2 below to authorize disclosure of protected medical and/or billing information. Section 3 is for authorization to leave messages on answering machines.

## 1. DISCLOSURE

Choose one of the following:

- ☐ Access to medical information;
- ☐ Access to billing information; or
- ☐ Access to medical and billing information.

Recipient of the information: (Please provide name and phone number)

- ☐ Spouse _____
- ☐ Other _____

## 2. DISCLAIMER *(initial below)*

_____ I do not want you to discuss my medical care with anyone other than myself.

For voluntary marketing and fund raising activities:
□ Yes, I would like to participate □ NO, I would prefer not to participate

## 3. ANSWERING MACHINE *(initial one of the following)*

_____ I authorize The Center for Physical Medicine and Pain Management to leave messages on my home answering machine and/or cell phone.
_____ I DO NOT authorize The Center for Physical Medicine and Pain Management to leave messages on my home answering machine and or cell phone.

I hereby authorize you to use or disclose my protected medical and/or billing information only to the parties listed above. This authorization shall remain in effect from the date signed below until written notice received by patient.

**Patients Signature** **Date**

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
## NOTICE OF PRIVACY PRACTICES

This is your HIPAA mandated notice that apprises patients of their rights with regard to protected health information

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization in writing at any time to obtain a current copy of the *Notice of Privacy Practices* which provides a more complete description of the uses and disclosures of my health information.

I have been notified:

- In case of a breach of Protected Health Information, I will be notified.
- I have the right to an electronic copy of my medical records within the given time frame set by CMS.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

I have been notified:

- I have the right to restrict disclosure of encounter information to an insurer, including Medicare, if I paid fully out of pocket for the encounter.
- The Center for Physical Medicine & Pain Management may use or disclose your protected health information to provide you with information about treatment alternatives or other health-related services that may be of interest to you or for voluntary fund-raising activities that may benefit our medical practice. You may opt out of the voluntary marketing and fund raising activities by indicating the appropriate box on your Medical Disclosure Authorization form.

**Patient Name:** _____

**Signature:** _____

**Date:** _____

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## OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

| _____ | _____ | _____ |
|---|---|---|
| **Date** | **Initials** | **Reason** |

**The Center For**
**Physical Medicine and Pain Management, P.C.**
**Rachelle Janush, D.O.**
**2227 Taylor Road Suite $ Montgomery, AL 36117**
**Office: 334-260-8988 $ Fax: 334-260-8225**

# *Notice of Privacy Practices*

Date of Adoption: December, 2010

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

## Introduction

We value the trust you have placed in us. Because our relationship with you is so important, the protection of your privacy has always been a particular concern of our physicians and staff. Confidentiality has been a principle that we have always taken seriously.

When you receive care at The Center For Physical Medicine and Pain Management, PC or at another site B such as a hospital B from one of our physicians or other health care professionals, a record of your visit is made. Depending upon the nature of your visit, this record may include a variety of information about you such as the reason for the visit; pertinent history, examination and test results; impressions; diagnoses; treatment; a plan for future care or treatment; and the like.

Federal laws B such as The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules B require medical practices and other covered entities to maintain the privacy of health information and to provide patients with a written *Notice of Privacy Practices* that outlines our legal duties and how the protected health information we maintain may be used or disclosed to others. The HIPAA mandated notice is to apprise our patients of their rights with regard to protected health information.

**We are required to abide by the terms in the current notice; however, we reserve the right to change privacy practices when deemed appropriate**. Every patient is welcome to review S or request a copy of S the current *Notice* at any time. A copy of the most current notice will be posted next to the registration desk. A copy will also appear on our website when construction is complete.

**Should you have any questions or concerns about this notice, or wish to obtain a copy of the current *Notice*, please contact our Privacy Officer/Contact B Mrs. Cindy Sullivan Assistant Office Manager. In her absence, please contact Dr. Rachelle Janush.** You may contact either of them by phone at 334-260-8988; or by email at gcraig@cpmpm.net.

**As a basic rule, The Center For Physical Medicine and Pain Management, PC's policy is to maintain confidentiality over your health care information in accordance with this notice**. We will NOT sell or Arent@ your information. The Center For Physical Medicine and Pain Management, PC does not disclose any personal health information except as permitted and/or required by state and Federal laws.

**Our employees are trained in the importance of privacy/confidentiality**. Maintaining privacy is part of their job responsibilities and employees may be disciplined if they do not adhere to our privacy policies and procedures.

Thank you for selecting us as your physician.

## Uses and Disclosures of Protected Health Information for Treatment, Payment and Operations

*Protected health information* includes demographic information that may identify you and medical information about your past, present or future physical or mental health or conditions and related health care services provided to you.

We may release protected health information for purposes of *treatment, payment or health care operations*. That is, your protected health information may be used and disclosed by your physician, The Center For Physical Medicine and Pain Management, PC office staff, and certain others outside our office that are involved in your care, for purposes of treatment, filing health insurance claims, processing patient bills, quality improvement programs, to support The Center For Physical Medicine and Pain Management, PC's operations, etc.

**TreatmentB**

It is essential that The Center For Physical Medicine and Pain Management, PC=s physicians and staff, and other physicians, nurses, hospitals, etc., that are involved in your care have necessary information to diagnose, treat, and provide health care services to you. We may use and disclose protected health information to provide, coordinate, or manage your health care and related services. We may disclose your health information to other physicians involved in your care, as well as hospitals, laboratories, diagnostic centers, home health agencies, and the like that may be involved in your care.

**PaymentB**

Your protected health information may be used to file health insurance claims and billing statements for health care services provided to you, to check insurance eligibility, to obtain authorizations for services, to collect unpaid accounts, and the like.

**Health Care OperationsB**

We may use or disclose protected health information for what is called *Health Care Operations* under federal law. Some examples include: quality improvement to send appointment reminders to you; to send announcements of new physicians, staff and services; to phone in prescriptions to your pharmacist; to train employees and medical students; administrative management; and the like.

Whenever protected health information is provided to certain Business Associates B such as billing services, medical record transcription services, computer vendors, business consultants, collection agencies, etc. B we are required to obtain contractual assurances that the Business Associate will take appropriate steps to protect your health care information. Further, legislation that became effective in 2013 makes Business Associates directly subject to most of the HIPAA privacy regulations for protection of patient information, including the requirement to notify us of breaches of unsecured protected health information. We do not, however, have direct control over Business Associates beyond contractual assurances.

## Uses/Disclosures of Health Information Based Upon Your Written Authorization

Note: This section applies to uses/disclosures of health information that are not related to Treatment, Payment or Health Care Operations.

**There are certain types of uses and disclosures that we will make only if you have signed a specific Authorization for the use or disclosure**. For example, we will not release information to a disability insurance company or a life insurance company without an authorization signed by you (or your personal representative). We will not release protected information to your employer without a specific authorization signed by you (or your personal representative). [Note: There are some employers that may receive protected health information B for purposes of treatment, payment or health operation Bif they administer health plans.]

In the event you have authorized us to release specific information, you may revoke the authorization, at any time. However, we are not responsible to the extent any action has already been taken in reliance of the original authorization.

## Announcements, Notices of Services, Newsletters, Marketing, Etc.

We may use or disclose your protected health information to provide you with information about treatment alternatives or other health-related services that may be of interest to you or for voluntary fund-raising activities that may benefit our medical practice.

We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, new physicians joining our practice, availability of new treatments and services, and the like.

**We do not sell lists of patients to third parties, or disclose protected health information to a third party for independent marketing activities**. In the unlikely event that we change this policy in the future, we will not release your name or health information without your express written authorization.

Occasionally, we may send you information about health care products or services that we believe may be beneficial to you. We are not currently involved in any arrangements where we are paid by a third party for marketing. Should that change in the future, any communication will include a statement indicating we are compensated by a third party for marketing products or services, and we will obtain your written authorization for such communications.

You may opt out of the voluntary marketing and fund raising activities by signing the Medical Disclosure Authorization form.

For further information you may contact our Privacy Officer/Contact specified on page one. You may also contact our Privacy Contact/Officer to request that such information no longer be sent to you.

## Uses and Disclosures Required By Law

**Protected health information may be used or disclosed to the extent that the use or disclosure is required by law**. Consequently, we may be required to disclose relevant protected health information as directed by a public health authority that is permitted by law to collect or receive such information for purposes such as controlling/preventing disease, injury or disability. If required by law or at the direction of a public health authority, we may disclose relevant protected health information to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

We may be required to disclose relevant protected health information to a government agency that is authorized by law to receive reports of child abuse or neglect; elderly (or other) abuse or neglect; domestic violence; and the like. Any such reports will be made as required by law.

We may be required to disclose protected health information to a health oversight agency for activities authorized by law, such as inspections, audits, investigations, etc. We may disclose your protected health information as may be required by the Food and Drug Administration or similar agency to report reactions, potential product defects, to facilitate product recalls or warnings; and the like.

We may be required to disclose protected health information in response to a valid court or similar order or subpoena. We may be required to disclose protected health information for law enforcement purposes, so long as applicable legal requirements are met. We may disclose protected health information to a medical examiner, coroner, etc. We may disclose protected health information required by funeral directors to fulfill their duties. We may disclose information to organ donation programs (to which the patient has indicated interest).

As provided by federal and state laws, we may disclose health information if we reasonably believe it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

We may disclose health information requested by national security and intelligence agencies, appropriate military command authorities, the Department of Veterans Affairs to determine eligibility for veteran's benefits, and the like. Your protected health information may be disclosed by us to comply with workers compensation laws and other

similar programs.

## Disclosures to Family Members and Others Involved in Your Health Care

Consistent with the exercise of professional judgment and experience as to your best interests, we may disclose S unless you direct otherwise S to a member of your family, a relative, a close friend or personal representative your protected health information *that relates to that individual=s involvement in your current health care* or payment of that care, to assist in locating/notifying family members, and the like.

We will to the extent possible, limit such disclosures based upon a Aneed to know@ philosophy and use professional judgment to limit the type of information disclosed to that reasonably deemed proper under the circumstances. If patients come to the exam room with their spouse, adult children, or friend, we may reasonably infer that you want them to be involved in your health care. This does not mean we will necessarily disclose your complete past history, all current conditions, etc. that are not relevant to the current circumstances.

We will use professional judgment and experience to make reasonable inferences of your best interests in allowing a person to act on the patient's behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information.

We have adopted this policy rather than a strict prohibition on ever discussing information relevant to your health care with these individuals. We will make all reasonable efforts to avoid disclosure to individuals not involved in your health care, or in situations where disclosure is not in your best interest.

You have the right object to such disclosures in writing, or by taking actions indicating a desire to excuse another individual so that we may talk privately. **Please discuss any concerns you have with our Privacy Officer/Contact who is identified on the first page, or your health care professional**.

## Emergencies

We may use or disclose relevant health information in emergency situations where we believe, in our professional judgment, that the information is necessary to determine proper treatment, to prevent further harm to you, or is in your best interest and it is not reasonably possible to obtain an authorization or consent.

## Research

We may disclose health information for research purposes that has been de-identified so that there is no reasonable way that researchers could match your name with health information, based upon a specific authorization signed by you or your personal representative, or for research programs that have been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information. For example, researchers may obtain approvals to study the medical records of middle-aged women, diagnosed with various degrees of heart disease, to identify potential risk factors for heart disease.

Please note that the previous paragraph is related to the use and disclosure of health information for research, not to any agreement to participate in a clinical trial that may involve experimental drugs, experimental procedures or treatment, and the like. Should you be a candidate for such clinical trials, you will have the opportunity to agree to B and consent to B participation.

## Other Permitted and Required Uses

Other uses or disclosures of protected health information not listed in this Notice will generally require a patient’s (or their representative’s) specific authorization. You have the right to revoke such authorizations by submitting a request to the Privacy Officer/Contact listed on the first page.

## Your Rights Regarding Your Health Information

You have certain rights with respect to the use and disclosure of your protected health information. This information includes information used to make health care decisions or information used to determine whether an insurance claim will be paid.

The specific rights that we must include in this notice are discussed below. Even if a right is not listed here, please discuss any concerns or make requests you have with our Privacy Contact/Officer (the name and phone number is provided on the front page). We will make all reasonable efforts to address your concerns. You can contact the Privacy Officer by phone to discuss requests; however, we may have to require a formal request, submitted in writing, to ensure it is handled appropriately.

## Right to Inspect and Copy Your Protected Health Information

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a written or electronic copy of protected health information about you for as long as we maintain such information. Because we must maintain the complete original copy of your health information, we may limit inspection to copies of the original information.

State and federal law provides some exceptions where we may withhold certain information. For example, we may deny access to psychotherapy notes. We may also deny access to information that a law enforcement or other governmental agency has instructed us not to disclose pending civil, criminal or other proceedings.

While a denial of your right to inspect and copy would be unusual, any denial is reviewable. Should you have any questions, concerns or wish to request a review, please contact our Privacy Contact/Officer designated on the first page. In the event you are requesting a review of a denial to inspect or copy protected information, you should file a written request which is a simple statement signed by you or your representative. Such review will be based upon federal and/or state law.

## There May Be a Reasonable Charge for Making Copies of Your Medical Record as Allowed by State and Federal Law.

While we will strive to fulfill a request as soon as possible, federal law states that we must: AAct on a request for access within 30 days of receiving the request if the information is maintained or accessible on-site. Covered entities must act on a request for access within 60 days of receiving the request if the information is not maintained or accessible on-site. If the covered entity is unable to act on a request within the applicable deadline, it may extend the deadline by no more than 30 days by providing the individual with a written statement of the reasons for the delay and the date by which the covered entity will complete its action on the request. This written statement describing the extension must be provided within the standard deadline. A covered entity may only extend the deadline once per request for access.@

## Right to Request Restrictions on the Release of Information

You also have the right to request that health information not be released for any purpose for which you have not completed a specific authorization. For example, patients may request that The Center For Physical Medicine and Pain Management, PC not release information for purposes of treatment, payment, or health care operations. While The Center For Physical Medicine and Pain Management, PC does not have to agree to such requests, we will consider your request to determine if there are *reasonable* ways to meet your needs or concerns. You may be asked to make special payment arrangements if requesting restrictions on release of information for payment purposes such as filing health insurance claims. Such requests should be made in writing and presented to the Privacy Officer/Contact identified on the first page of this *Notice*.

As of February 18, 2010, the medical practice must honor requests not to disclose protected health information (for purposes of payment or health care operations) if the patient pays the entire cost of treatment out-of-pocket. Prior to

February 18, 2010, the medical practice did not have to agree with these requests.

## Right to Receive Confidential Communications

Communications from our office to patients are made to the address and phone numbers in our information system.

You have the right to request *confidential* communications of protected health information. For example, a patient who does not want his or her family members to know about a certain treatment may request that we communicate with the individual about that treatment at the individual's place of employment, by mail to a designated address, or by phone to a designated phone number. Similarly, a patient may request that we send communications in a closed envelope rather than a post card, as an "alternative means." We will try to accommodate all *reasonable* requests.

We suggest that you provide an address, phone numbers, etc. so that we may communicate with you at your desired location. If you are requesting special handling of certain types of information, the request must be in writing and it must detail where communications should be made. You are not required to provide a reason for the request. We will determine if we can accommodate any request based upon the administrative difficulty of complying with the request.

> **Please note that we are only responsible for information sent from The Center For Physical Medicine and Pain Management, PC.** You must make a similar request to others entities if you have concerns about communications from other medical practices, health insurance companies, hospitals, etc.

## Right to Amend Protected Health Information

A patient has the right to request amendment to protected health information as long as the protected health information is maintained by this medical practice. Requests for amendments should be submitted to the Privacy Contact/Officer listed on the first page of this Notice. While you can discuss such requests over the phone, we may require formal requests to be submitted in writing and to include a reason(s) to support a requested amendment.

We may deny a request for amendment if we determine that the protected health information is accurate and complete; or the record that is the subject of the request does not exist in our files or was not created by this medical practice (unless the individual provides a reasonable basis to believe that the originator of such information is no longer available to act on the requested amendment).

While we will attempt to fulfill the request as soon as possible, federal law allows up to 60 days to act either by making the appropriate amendment or sending you a written denial with the reason(s) for denying the request. Federal law also allows for one 30 day extension in certain circumstances.

In the event your request for amendment is denied, you have additional rights that will be detailed in any denial notification including: how you may file a complaint; the right to submit a written statement disagreeing with the denial and how you may file such a statement; or the right to request that the covered entity provide the individual's request for amendment and the denial with any future disclosures of the protected health information that is the subject of the amendment; and the like.

## Right to an Accounting of Certain Disclosures

You have the right to request an accounting of certain disclosures of your protected health information occurring up to six years preceding such request. Because, federal law recognizes that it would burdensome to account for disclosures for purposes of treatment, payment, and operations, we are not required to account for such disclosures. Also, Federal law does not require an accounting for disclosures that you authorized and provides a few other exceptions to this requirement.

While we will attempt to comply with a request as soon as possible, federal law allows up to 60 days to act either by making the appropriate accounting or extending the time period by up to 30 days by sending you a written statement with the reason(s) for the delay.

You are allowed one accounting within a 12 month period without charge. Further requests may be subject to a reasonable charge. Requests for an accounting should be submitted to the Privacy Contact/Officer listed on the first page of this Notice. While you can discuss such requests over the phone, we may require formal requests to be submitted in writing.

## Right to Receive a Paper Copy of This Notice

Our patients, who may have received this *Notice of Privacy Practices* in electronic format, may contact the Privacy Officer to request a printed copy.

## Charging for Copies of Records

We reserve the right to charge a reasonable amount for copying records and mailing costs consistent with state and federal laws.

## Changes to this Notice of Privacy Practices

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time, either as required by law or as otherwise necessary. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. We may require requests made over the phone to be submitted in writing or in person.

A copy of this notice will be posted in an accessible area in each of our offices and other facilities. A copy of this form will also appear on our Web Site when constructed.

## Complaints

You may file a complaint or express your concerns to us by contacting the Privacy Officer listed on the first page of this document. We will not retaliate against you for filing a complaint. For further information about the complaint process, please contact our Privacy Officer listed on the first page. You may also discuss concerns with your physician.

We urge you to contact our Privacy Officer with any questions or concerns you may have regarding this notice. Thank you for your assistance.

Or, you may complain to the U.S. Department of Health & Human Services, Office of Civil Rights (OCR) Regional Office or OCR Headquarters if you believe your privacy rights under the Health Insurance Portability and Accountability Act (HIPAA) have been violated by us. You may contact the OCR at this toll free number: 1-800-368-1019.

Director
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909
Voice Phone (404)562-7886
FAX (404)562-7881
TDD (404)331-2867

Additional instructions are available at the U.S. Department of Health & Human Services, Office of Civil Rights (OCR) Regional Office or OCR Headquarters. Instructions are also available on the OCR Web site at:

www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

# Breach Notification Requirements

In the event that a breach of unsecured protected health information occurs, we (and our Business Associates) are required to make certain notifications under section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act. Such notification, following a breach of unsecured protected health information, will be made to affected individuals, the Department of Health and Human Services, and, in certain circumstances, to the media. In addition, our business associates must notify us in the event a breach of unsecured protected health information has occurred.

Individual Notice will be provided in written form by first-class mail, or alternatively, by e-mail if the affected individual has agreed to receive such notices electronically. If we have insufficient or out-of-date contact information for 10 or more individuals, we must provide substitute individual notice by either posting the notice on the home page of our web site or by providing the notice in major print or broadcast media where the affected individuals likely reside. If we have insufficient or out-of-date contact information for fewer than 10 individuals, the covered entity may provide substitute notice by an alternative form of written, telephone, or other means.

These individual notifications must be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach and must include, to the extent possible, a description of the breach, a description of the types of information that were involved in the breach, the steps affected individuals should take to protect themselves from potential harm, a brief description of what the covered entity is doing to investigate the breach, mitigate the harm, and prevent further breaches, as well as contact information at our medical practice. Additionally, for substitute notice provided via web posting or major print or broadcast media, the notification must include a toll-free number for individuals to contact the covered entity to determine if their protected health information was involved in the breach.

Covered entities that experience a breach affecting more than 500 residents of a State or jurisdiction are, in addition to notifying the affected individuals, required to provide notice to prominent media outlets serving the State or jurisdiction. Covered entities will likely provide this notification in the form of a press release to appropriate media outlets serving the affected area. Like individual notice, this media notification must be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach and must include the same information required for the individual notice.

If a breach of unsecured protected health information occurs at or by a business associate, the business associate must notify our medical practice following the discovery of the breach. A business associate must provide notice to our medical practice without unreasonable delay and no later than 60 days from the discovery of the breach. To the extent possible, the business associate should provide our medical practice with the identification of each individual affected by the breach as well as any information required to be provided by us in notifying affected individuals.

## Acknowledgment of Receipt of this Notice

You will be asked to sign a form indicating that you have received this Notice. This acknowledgment form is required by Federal law. Your signature does not affect your privacy rights; it merely indicates you have received a copy of this Notice. If you have not signed the Acknowledgment form, please notify a member of our staff or notify the Privacy Officer/Contact listed on the first page.

## Final Comment

We reaffirm our commitment to protecting your health information. Should you have any concerns or questions related to your rights, please contact our Privacy Officer/Contact listed on the first page of this Notice. Our Privacy Officer will strive to answer your questions and address your concerns.

We were committed to preserving the confidentiality of your patient information long before this relatively new Federal Law was enacted. We believe our past and future actions will convey our commitment much more than the language included in this Notice.

Thank you for selecting our medical practice and cooperating with us to comply with this law.

**The Center for**
**Physical Medicine & Pain Management, P.C.**
***Rachelle Janush, D.O.***
2227 Taylor Road ♦ Montgomery, AL 36117
Office: 334-260-8988 ♦ fax: 334-260-8225

# PATIENT QUESTIONNAIRE

## 1. WHO REFERRED YOU TO DR. JANUSH?

☐ Self ☐ Friend / Patient ☐ Relative ☐ Dr. _____ ☐ Internet

## 2. INJURY HISTORY

What type of injury are you being seen for?

☐ Worker compensation ☐ Motor vehicle ☐ None ☐ Own fault injury
☐ Other: _____

If you have been involved in a motor vehicle accident and you are seeking treatment as a result of your accident, please ask to speak with a billing representative prior to seeing the doctor.

Briefly describe your injury. (Include the date, where, and how)

When: _____

Where:
_____
_____

How:
_____
_____
_____

List any previous injuries. (Include the date, where, and how)

_____
_____
_____

## 3. IS THIS A WORKER'S COMPENSATION CLAIM?

☐ No

☐ Yes – Our office must have your claim number and approval from you w/c carrier prior to being seen by the doctor.
Claim Number _____
**W/C allowable injury area**: _____

## 4. MY CURRENT ATTORNEY FOR LEGAL REPRESENTATION IS

Attorney name _____
☐ No legal litigation pending

**If you have an attorney representing you in connection with your problem, please ask to speak with a billing representative prior to seeing the doctor.**

## 5. WHO IS YOUR PRIMARY CARE (family/internal medicine) DOCTOR?

_____

Do you want your medical records sent to him/her? ☐Yes ☐No

## 6. LIST ALL DOCTORS WHO HAVE TREATED YOU IN THE LAST 5 YEARS

_____
_____
_____

## 7. LIST ALL CURRENT PHARMACIES

1. Name & Address: _____ Telephone: ( ) _____
2. Name & Address: _____ Telephone: ( ) _____
3. Name & Address: _____ Telephone: ( ) _____

## 8. HOW HEALTHY DO YOU FEEL?

**Please Circle where appropriate:**

| | | Suffering | Poor | Average | Good |
|---|---|---|---|---|---|
| a. | Smoke _____ years / _____ packs per day | | | Stopped _____ years ago \| _____ N/A | |
| b. | Family history of substance abuse - | alcohol | | illegal drugs | prescription drugs |
| c. | Personal history of substance abuse - | alcohol | | illegal drugs | prescription drugs |
| d. | Personal mood disorders - | depression | | attention deficit disorder | bipolar, schizophrenia |
| e. | Alcohol number of drinks per day - ___ | daily night cap __ | | weekends | _____ none or occasional |
| f. | Alcohol / substance abuse treatment | none | | _____ year | _____ currently |
| g. | Released from medical pain treatment due to ETOH | prescription | Illegal drugs | None | Yes |
| h. | I was in medical treatment drug treatment program. Yes | When _____ / How long? _____ | | | No |

## 9. PAIN HISTORY

How did the pain start?
☐ Injury ☐ Bending ☐ Fall ☐ Lifting ☐ Gradually ☐ Don't know

Describe the pain:
☐ Aching ☐ Burning ☐ Tingling ☐ Numbness
☐ All the time ☐ Constant ☐ Episodic ☐ Shooting

Pain is located in:
☐ Left leg / Knee / foot ☐ Upper back ☐ Neck ☐ Hip R / L ☐ Arm R / L
☐ Right leg / Knee / foot ☐ Lower back ☐ Head ☐ Shoulder R / L

What activities make the pain worse?
☐ After exercise ☐ Walking ☐ Sitting ☐ Lying down
☐ During exercise ☐ Sneezing ☐ Standing ☐ Being still
☐ Other: _____

What reduces the pain?
☐ Lying down ☐ Medication ☐ Sitting ☐ Standing ☐ _____

How long have you had this pain?
☐ ____ Days ☐ ____Weeks ☐ ____ Months ☐ ____ Years

## 10. ARE YOU A MILITARY VETERAN?

☐ YES ☐ N0

Branch of service:
☐ Army ☐ Navy ☐ Marines ☐ Coast Guard ☐ Air Force ☐ National Guard

## 11. WORK HISTORY

Are you currently working?
☐ Yes ☐ No – date last worked _____ ☐ Retired/Disabled
Current Occupation: _____: For _____ years
Previous Occupation: _____

Number of hours per week:_____ ☐ Regular Duty ☐ Light Duty

Do you plan to be at your regular job in six months?
☐ Yes ☐ No

Highest education level.
☐ _____ Grade ☐ G.E.D. ☐ High School Graduate ☐ Technical ☐ College Grad.
☐ Doctoral / Ph.D ☐ Some College

## 12. PAIN INVENTORY (0 = NO PAIN – 10 = WORST PAIN)

Pain level on average: _____ Last week Past pain treatment: _____ Helped to reduce pain
Worst pain level: _____ Last week At what level of pain can you function well? Level _____

Has pain affected your relationship with: Check all that apply
☐ Spouse / Significant Other ☐ Children / Family ☐ Friends ☐ Employer

How much time does pain cause you to miss work or prevent household chores?
☐ < 25% ☐ 25-50% ☐ 50-75% ☐ 75-100%

Do you feel the need to cut down your alcohol or drugs or prescription medication use?
☐ Yes ☐ No

Have you ever been abused illicit or prescription medications?
☐ Yes ☐ No

Have you ever been treated for abuse of illicit or prescription medications?

☐ Yes ☐ No

## 13. HAS ANY OF YOUR IMMEDIATE FAMILY BEEN DIAGNOSED WITH AN ADDICTION? IF SO, PLEASE LIST THE SUBSTANCES.

☐ Yes: _____
☐ No

## 14. EXERCISE HISTORY

What type of exercise do you do?

☐ Aerobics ☐ Biking ☐ Running ☐ Swimming ☐ Walking ☐ Basketball
☐ None ☐ Stretch ☐ Tennis ☐ Yoga
☐ Other: _____

How often do you do each of the above exercises?
Daily____ Weekly_____ Minutes_____ Never_____

## 15. YOUR MEDICAL HISTORY (Circle all that apply)

| | |
|---|---|
| *Blood* | *Anemia / Bleeding / Blood clots / Hepatitis A \| B \| C / Cancer / HIV/AIDS* |
| Bone | Arthritis / Osteoporosis |
| Cancer | Breast / Colon / GI / Lung / Skin / Prostate |
| Cardiovascular | Bypass / CABG / Dysrhythmia / DVTS / Edema / Heart Disease / High Blood Pressure Hypercholesterol / MVP / Palpations / Varicose Veins |
| Ears | Deafness / Hard of Hearing / Hearing Aid / Ringing |
| Endocrine | Cancer / Diabetes I, II / Gout / Hypothyroid / Hyperthyroid / Night sweats |
| Eyes | Blindness / Cataracts / Glasses / Glaucoma / Visual changes |
| Gastrointestinal | Constipated / Diarrhea / Incontinence / Gallbladder/ Nausea and Vomiting / Reflux / Ulcers |
| Musculoskeletal | Amputation / Back pain / Joint pain / Muscle Loss / Neck pain / Pain / Weakness |
| Neurological | Headaches / Head Injury / Memory Loss / Migraine / Numbness / Seizures / Stroke / Tingling Tumor |
| Nose / Mouth / Throat | Allergies / Dentures / Hoarsness / Sinusitis |
| Psychiatric | Anxiety / Bipolar / Depression / Schizophrenia |
| Respiratory | Apenia / Asthma / Bloody Cough / Emphy/COPD / Oxygen / Pneumonia / Shortness of Breath Sleep Apnea / TB |
| Sexual difficulty | Interest / Performance / Pain / Impotence / Poor Strength Erection |
| Skin | Cancer / Rash / Shingles / Sores |
| Urinary | Cancer / Dialysis / Incontinence / Infection / Prostate / Renal Failure / Stones / Straining |
| *Weight* | *Obese / Overweight / Thin / Weight Loss-Intentional / Unintentional* |

## 16. PAST SURGICAL HISTORY

| | | Year in hosp. | | | Year in hosp. |
|---|---|---|---|---|---|
| Appendectomy | ☐Yes | _____ | Gastric Bypass | ☐Yes | _____ |
| Bypass heart \| vein | ☐Yes | _____ | Hysterectomy | ☐Yes | _____ |
| Cancer surgery | ☐Yes | _____ | Neck laminectomy | ☐Yes | _____ |
| Foot surgery R \| L | ☐Yes | _____ | Low back laminectomy | ☐Yes | _____ |
| Gallbladder | ☐Yes | _____ | Shoulder surgery R \| L | ☐Yes | _____ |

All others: _____

## 17. PREVIOUS TREATMENT TRIALS

| | Who | | Did this help? | |
|---|---|---|---|---|
| Chiropractic | ☐Yes | _____ | ☐Yes | ☐No |
| Epidural block | ☐Yes | _____ | ☐Yes | ☐No |
| Medications | ☐Yes | _____ | ☐Yes | ☐No |
| Nerve block | ☐Yes | _____ | ☐Yes | ☐No |
| Physical therapy | ☐Yes | _____ | ☐Yes | ☐No |
| Steroid injection | ☐Yes | _____ | ☐Yes | ☐No |

## 18. PREVIOUS STUDIES

| | | Where & When |
|---|---|---|
| EMG – nerve study | ☐Yes | _____ |
| CT scan | ☐Yes | _____ |
| MRI | ☐Yes | _____ |
| X-ray films | ☐Yes | _____ |
| Psychology evaluation | ☐Yes | _____ |

## 19. LIST ALL MEDICATIONS CURRENTLY TAKING, INCLUDING OVER THE COUNTER, AND OTHER MEDICATIONS YOUR HAVE TRIED FOR PAIN BUT ARE NO LONGER TAKING.

_____
_____
_____
_____

**NOTE ** Dr. Janush will not change nor begin medication until diagnosis is confirmed by review of records, lab, X-ray, EMG, or further testing. Patient so advised by Dr. Janush.**

## 20. ALLERGIES:

_____
_____
_____
_____

## 21. SOCIAL HISTORY

☐Single ☐Married ☐Divorced ☐Widow ☐Partner

I am a caretaker for ill _____
☐Yes ☐No

Number of children _____.
☐Living with Parents / Children / Residential Assistance

## 22. FAMILY HISTORY

List all family members that have the following conditions (Check all that apply)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Arthritis | ☐GrM | ☐GrF | ☐Mother | ☐Father | ☐Sibling | ☐Child | ☐Don't Know |
| Cancer | ☐GrM | ☐GrF | ☐Mother | ☐Father | ☐Sibling | ☐Child | ☐Don't Know |
| Diabetes | ☐GrM | ☐GrF | ☐Mother | ☐Father | ☐Sibling | ☐Child | ☐Don't Know |
| Heart disease | ☐GrM | ☐GrF | ☐Mother | ☐Father | ☐Sibling | ☐Child | ☐Don't Know |
| Stroke | ☐GrM | ☐GrF | ☐Mother | ☐Father | ☐Sibling | ☐Child | ☐Don't Know |
| Hypertension | ☐GrM | ☐GrF | ☐Mother | ☐Father | ☐Sibling | ☐Child | ☐Don't Know |
| Adopted | ☐Unknown family history | | | | | | |

## 23. FUNCTIONAL HISTORY

| | | | | |
|---|---|---|---|---|
| Driving | ☐Independent | ☐Need help | ☐Don't drive | |
| Grooming | ☐Independent | ☐Need help | | |
| Self feed | ☐Independent | ☐Need help | | |
| Speech | ☐Independent | ☐Need help | ☐Wheelchair | |
| Toilet | ☐Independent | ☐Need help | ☐Working | |
| Walk | ☐Independent | ☐Need help | ☐Walker | ☐Cane |
| Home Chores | ☐Independent | ☐Need help | | |
| Grocery buying | ☐Independent | ☐Need help | | |
| Cleaning | ☐Independent | ☐Need help | | |
| Cooking | ☐Independent | ☐Need help | | |

## 24. AVOCATIONAL ACTIVITY

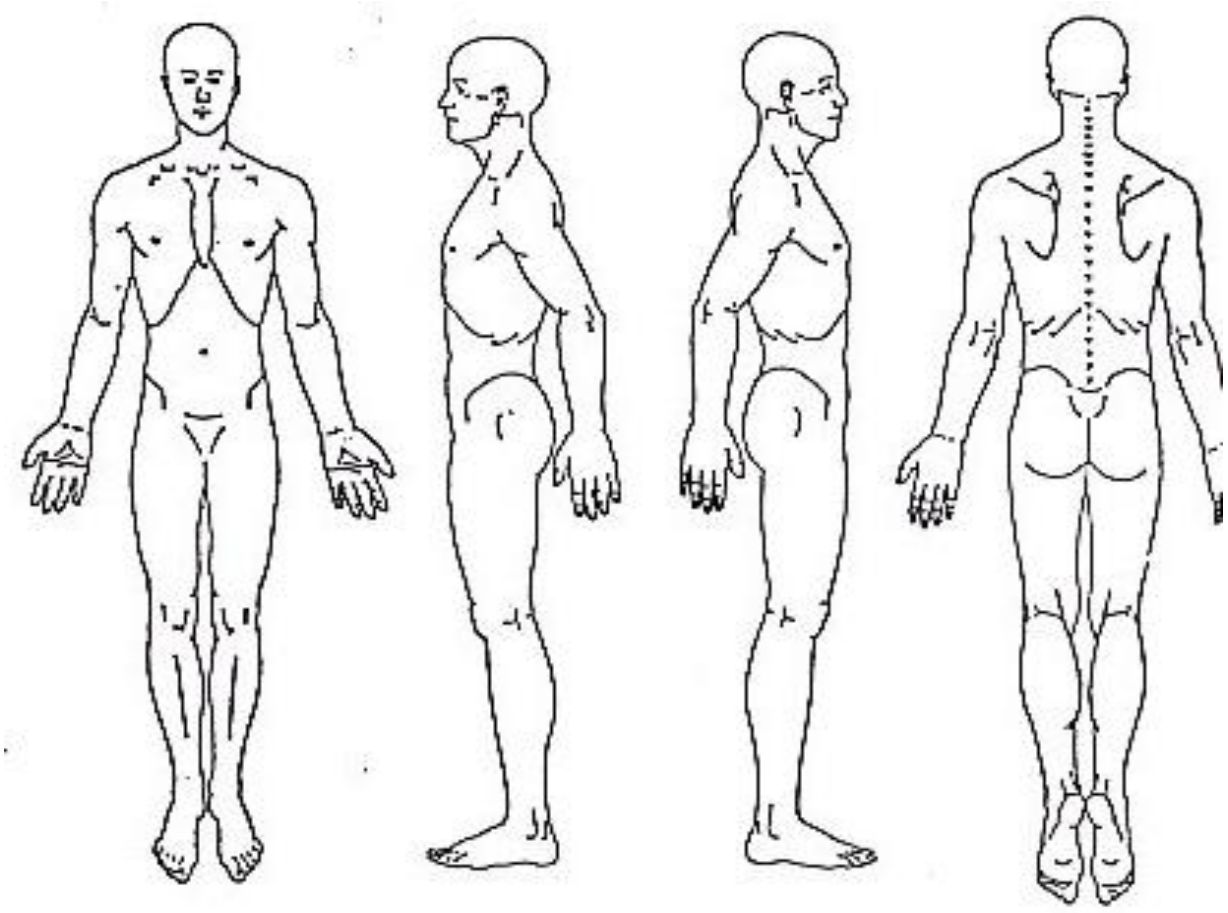
My hobbies include _____
☐I am now in ☐bed only ☐sitting only ☐not moving because it hurts.
☐Volunteer work _____

## 25. PATIENT GOAL

☐Reduce pain

PLEASE COMPLETE
DIAGRAM

PLEASE WRITE ON THE FIGURES BELOW THE TYPE OF PAIN YOU ARE EXPERIENCING. MARK WITH AN "X" WHERE SEVERE PAIN IS PRESENT AND "CIRCLE" WHERE PAIN IS PRESENT.



**PLEASE INITIAL TO ACKNOWLEDGE THAT YOU HAVE READ THE FOLLOWING STATEMENTS.**

****_____ Today's consultation and evaluation does not constitute Dr. Janush's agreement to enter into a physician patient relationship. This decision will be decided upon completion of the initial visit.**

****_____ For my safety Dr. Janush will NOT prescribe any medication until previous medical records are received and reviewed, and lab testing completed.**

Patient Signature: _____ Date: _____

# Financial Policy

**The Center for Physical Medicine & Pain Management**
2227 Taylor Road
334-260-8988
Montgomery, AL 36117
334-260-8225 (fax)

This is an agreement between the Center for Physical Medicine & Pain Management, as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to the Center for Physical Medicine & Pain Management.

By executing this agreement, you are agreeing to pay for all services that are received.

**Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

**OPTIONS:** (Please choose an option)

**Payment options if you have no insurance:**

1. You choose to pay by __cash, __check, or __credit card on the day that treatment is rendered.
2. On treatment involving office visits only, entire visit charge must be paid at time services are rendered.
3. On treatment involving procedures, entire visit charge must be paid at time services are rendered.
4. A cash patient agreement with explanation of all charges will be explained and require your signature.
5. You may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution.
6. **All copays and deductibles are required to be paid at time services are rendered.**

**Payment options if you have insurance:**

1. You choose to pay your deductible and any out-of-pocket portions at the time services are rendered by __cash, __check, or __credit card.
2. You choose to pay all of your treatment by __cash, __check, or __credit card. We will request your insurance carrier send their payment directly to you.
3. **All copays and deductibles are required to be paid at time services are rendered.**

**Payments:** Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

**Charges to Account:** We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

**Preauthorization Fee:** If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from your insurance company and more out of pocket responsibility for you, denial of prescription and/or necessary testing and treatment. We will obtain the preauthorization for you; the fee for this service is $35 payable before authorization is processed.

**Billing Fee:** A service charge of $6 will be imposed on each account that is over thirty (30) days past-due. We determine your account is past-due by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

**Excessive Calls:** I understand that I will be charged for any phone calls longer than 15 minutes and/or for multiple calls in one 24 hour period.

**Returned checks:** There is a fee (currently $38) for any checks returned by the bank.

**Prescription fee:** All prescriptions must be obtained during your regular office visit. Any prescriptions outside the office visit will have a $25 service charge per prescription and must be paid before obtaining prescription. This includes any changes to prescriptions after your office visit. Your prescription can be shipped to you using UPS (ONLY) if you live out of the area for a UPS service charge of $25, this must be paid before shipping.

**Transferring of Records:** You will need to request in writing, and pay a reasonable copying fee that is incompliance with the HIPAA regulations at Section 164.524 (c)(4) if you want to have copies of your records sent to an organization or third party of your choosing. The amount of the fee is dependent on the number of pages copied or forms filled out. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history. You will be made aware of all cost BEFORE records are processed.

**Workers Compensation:** We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

**Co-signature:** If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

**Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect until written cancellation is received.

*The Center for Physical Medicine & Pain Management reserves the right to do periodic reviews of this financial policy and to update any changes according to new policies and new governing laws and make good faith effort to obtain written acknowledgment of receipt of the policy.*

**Patient's name**: _____

**Patients physical address** ***(NO PO BOX # ACCEPTED):***

_____

_____

**Responsible party**
**(if not the patient)**: _____

**Signature**: _____ **Date**: _____

**Co-Signature**: _____ **Date**: _____