



## 2025 Yearly CSP - Patient Paperwork

### HIPAA Signature Page

Acknowledgment of Receipt of "Notice of Privacy Practice"

I acknowledge that **Comprehensive Spine and Pain/Western Oklahoma Pain Specialist** has given me a copy of the Privacy notice either by web, email, US Mail, or in person by the federal government's HIPAA legislation. I have been provided the opportunity to discuss concerns I may have regarding the privacy of my health:

**Date:** \_\_\_\_\_ **Name of Patient:** \_\_\_\_\_

The government mandated that as of April 14, 2003, all health care patients are to receive from their clinicians a notice (hereafter referred to as "Notice") regarding the protection of their private health care information in compliance with the health insurance Portability and Accountability Act ("HIPAA") Privacy Rule (45 C.F.R. parts 150 and 154).

This form documents that your physician has given you the "Notice" that is required. HIPAA covers what is called "protected health information" (PHI) that is used for treatment, payment and health care operations. PHI is information in your health record that could identify you.

#### HIPAA

The Notice contains basic information about:

1. How your PHI may be used and disclosed for treatment, payment and healthcare operations (these terms are defined in the notice).
2. Which uses and disclosures require authorization from you and which do not.
3. How you may revoke an authorization you have made.
4. Certain rights you have to restrict use and disclosure of PHI, to receive confidential communications by alternative means and at alternative locations, to inspect and copy your records, to amend your records or to have an accounting of disclosures.
5. A list of my duties to protect the privacy of PHI, my right to change the privacy policies and practice described in the Notice, and how I will inform you of changes.
6. What you can do if you have any complaints about violations of your privacy rights, about decisions regarding access to your records I may make.
7. Any restrictions, any limitations you or I wish to put on the use and disclosure of your PHI.

Generally, this Notice is given to a patient in person, by email, or downloaded from the web. A copy of the Notice is available by request.

This page documents that you have received a copy of the Notice.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I have been offered or received and read the following documents:

1. HIPAA (a detailed copy of HIPAA is provided at our office)

#### I AGREE TO FOLLOW THESE POLICIES:

Print Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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### 2025 Pain Contract

In order to comply with state and federal regulations for the prescribing of controlled substances, you and your provider must enter into the following agreement. As an office, our goal is to provide a high quality, comprehensive treatment for chronic pain. This may include, but not limited to, interventional treatment (injection therapy), physical therapy and/or exercise, psychological evaluation/treatment, chiropractic care, or surgical evaluations. Your treatment plan may or may not include the use of narcotic pain medication. If opioids or other controlled substances are necessary to provide quality care, it is imperative to review this policy to ensure your safety.

*Please review all the information listed, as all policies within this agreement **will be enforced**. If you do not understand any of the information below, please ask. You are **required** to initial next to each item and sign this agreement stating you understand and will maintain compliance before receiving any pain medication.*

#### **PLEASE INITIAL NEXT TO EACH OF THE FOLLOWING:**

\_\_\_\_\_ I understand that **Dr. Brian Blick, Dr. Terrell Phillips, Dr. David Sharrah, Dr Luke Mosel or Dr. Richard Fair** is prescribing opioid pain medication and/or controlled substances for Chronic Pain Management

\_\_\_\_\_ My treatment plan has been discussed and agreed on by me and my provider. Alternative treatments and possible risks and complications of treatment have been explained to me. Having been informed of other treatment options and potential risks, I still **consent to receive medications for chronic pain**. I understand I must actively participate and comply with all aspects of my treatment plan and maintain responsible use of medications.

\_\_\_\_\_ I understand the initiation of narcotic/opioid medications and/or controlled substances **is a trial**. I understand continuation and dosage and/or changes will be determined by pain relief (my pain level), functional ability, any development of adverse side effects, new or worsening medical conditions, or if at any point, risks of medications outweigh benefits my provider may **reduce or eliminate medication** from my treatment plan.

\_\_\_\_\_ I **agree** to inform my provider of all medication I am taking, including all over the counter and/or herbal remedies, and any medication changes throughout the course of treatment. This is important given many drug-drug interactions that may cause potential adverse effects and outcomes. I agree to only take medications which are currently prescribed and all old prescriptions will be properly disposed of. .

\_\_\_\_\_ I **will** take my medication exactly **as instructed** by my provider. I **will not** change the dose or frequency without authorization from my provider. I understand taking these medications regularly may lead to **physical and/or psychological dependence**. They may also be associated with other risks including, but not limited to, decreased effectiveness, problems thinking clearly, itching, difficulty urinating, constipation, sleepiness/sedation, nausea, allergic reactions, slowing of reactions/reflexes, slowed breathing, or **overdose** and **death**.



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\_\_\_\_\_ I understand **sudden discontinuation or reduction** of my medication may lead to **withdrawal**. Symptoms of withdrawal include, but are not limited to, nausea, shakiness, increased heart rate, high blood pressure, diarrhea, abdominal pain/cramping, irritability, and flu-like feelings (runny nose, goosebumps, aching all over). I **agree** to discuss stopping or reducing my medications prior to doing so. If my provider discontinues my medication as a part of the treatment plan, non-compliance or dismissal, I will be provided with a tapering/weaning dose schedule to avoid negative withdrawals.

\_\_\_\_\_ I understand I **may become addicted** to these medications. Addiction is a chronic disease with genetic, psychosocial and environmental factors and is characterized by one or more of the following behaviors: you cannot control how you are using them, continuing to use them even when bad or dangerous things happen because of the medications due to cravings and/or compulsive use. I understand I am at increased risk if I have a *personal* or *family history* of alcohol or drug use/addiction or mental illness and **agree** to notify my provider of such history.

\_\_\_\_\_ I **agree**, I **will only** get my prescriptions for my pain from **Western Oklahoma Pain Specialists/Comprehensive Spine and Pain**. I will not fill any prescriptions or take medication given by another person or provider (Health, Dental, and Emergency Departments) without authorization from your provider. You **will** inform other treating healthcare providers of the medications you are being prescribed as a part of your chronic pain treatment plan.

\_\_\_\_\_ I understand taking more medication than is prescribed or medication from another source may lead to **overdose**, slowed or stopped breathing, permanent brain injury from lack of oxygen, coma, or **death**. I understand there is an increased risk of overdose when mixing opioid pain medications with medications that treat anxiety disorders or panic attacks, insomnia or seizures, or with using alcohol, illicit drugs, or any other central nervous system depressants (muscle relaxants). If you are prescribed any of these medications, including but not limited to, **benzodiazepines, barbiturates, sleep aids** or any new medication by another provider you **will** notify your provider immediately.

\_\_\_\_\_ I understand **Comprehensive Spine and Pain/Western Oklahoma Pain Specialists** upholds a policy of **limiting the amount of opioid pain medication** (morphine equivalent doses) as outlined in the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain and state law and **agree to comply**.

\_\_\_\_\_ I understand my medications are **required to last** for the duration prescribed. I **will not** share, sell or trade my medications or ask someone to obtain controlled medications for my use. I **will** safeguard my medications by keeping them in a safe place and away from children. It is recommended to keep them in a locked safe or cabinet. If my medication is lost, destroyed or stolen, I understand an **early refill will not be permitted** and may not be replaced as your provider reserves the right to taper or discontinue any medications which are lost or stolen.

\_\_\_\_\_ I **will** get my prescriptions for my pain from **one pharmacy**, when possible. Should the need to change pharmacies arise, I will inform my provider immediately. I understand my provider and staff have permission to discuss history, diagnostic and treatment details with dispensing pharmacies or other healthcare professionals involved in my care.

Pharmacy \_\_\_\_\_  
Location \_\_\_\_\_ Phone \_\_\_\_\_



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\_\_\_\_\_ I **will** inform my provider of **any changes** in medication (including prescribed or over the counter), medical history/condition, surgical history, relevant family history, social history, or domestic actions related to the use of opioids, narcotics, alcohol, or illegal substances.

\_\_\_\_\_ I **agree** to comply with **medication compliance monitoring** as needed which may include:

\_\_\_\_\_ I **agree** to being called to **random pill counts**, when requested. I understand I will have **within 24 hours** of the request to arrive at the office. Failure to comply or if results are inconsistent it is considered non-compliance and may result in medication taper/discontinuation and/or office dismissal.

\_\_\_\_\_ I **agree** to **random** urine, oral, blood, or hair **screenings**, when requested. Presence of illegal, unauthorized substances, the absence of prescribed medications or other abnormal results may result in medication taper/discontinuation and/or office dismissal. Refusal or failure to provide a sample for drug testing/screening when requested is considered non-compliance and may result in medication discontinuation and/or office dismissal.

\_\_\_\_\_ I **agree** to obtain a **Narcan “emergency kit”**, if asked, available from local pharmacies and/or clinics. Failure to comply may lead to discontinuation of medication and/or office dismissal.

\_\_\_\_\_ I **agree** to read all prescription bottles/labels/inserts and discuss any concerns or questions I may have regarding my treatment plan. This may include side effects, allergies, or contraindications to any medication.

\_\_\_\_\_ **(FEMALES ONLY)** To the best of my knowledge, I am **NOT pregnant**. If I **plan to become pregnant or believe that I am pregnant** while taking medications for my pain, I will **IMMEDIATELY notify Comprehensive Spine and Pain/Western Oklahoma Pain Specialists and my obstetrician**. I understand there are potential risks associated with chronic opioid therapy and other medications used to treat pain and pregnancy. If opioids are continued, the baby will be physically dependent at the time of birth and may require withdrawal. There may be birth defects or developmental delays which can occur.

\_\_\_\_\_ **(MALES ONLY)** I understand taking opioid pain medications may cause **low testosterone** levels and changes in sexual function (reduce stamina, sexual desire, physical and sexual performance)

\_\_\_\_\_ I **agree** to keep my scheduled appointments and to provide 24-hour notice to cancel. I understand if I fail to appear for more than 2 appointments, reschedule up to 3 appointments, or fail to comply with treatment plan (injections, physical therapy, referrals, etc.) I may be dismissed from care. It is my responsibility to reschedule missed or no showed appointments.

\_\_\_\_\_ I **understand** and **authorize** my doctor and my pharmacy to cooperate fully with all city, state, and federal law enforcement agencies, including the Oklahoma Board of Pharmacy, in the event an investigation arises from misuse, sale or other diversion of my medication. I **authorize** Comprehensive Spine and Pain/ Western Oklahoma Pain Specialists to provide a copy of this agreement to my pharmacy. I **agree** to waive all applicable privileges or right of privacy or confidentiality with respect to these authorizations.



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\_\_\_\_\_ I understand if at any time, my provider has any reason to believe I have violated the terms of this agreement or my treatment plan, my provider may terminate this agreement and my medications. A weaning dose will be provided if deemed necessary. If I wish to terminate this agreement, I will contact Comprehensive Spine and Pain / Western Oklahoma Pain Specialists for assistance.

Comprehensive Spine and Pain/Western Oklahoma Pain Specialists is committed to work with you in efforts to manage your pain. This agreement is intended to comply with the highest standards of medical care, as well as, state and federal laws related to chronic pain and most importantly, to ensure your safety.

We will help you schedule regular appointment times for medication renewals or refills. We will make sure your treatment plan is as safe as possible. We will check with you on side effects and keep track of your prescriptions and test for drug use regularly to monitor usage and compliance. We will connect you with other forms of treatment if needed for your condition. We will work with any other providers to help treat you safely and effectively. We will set treatment goals and monitor progress in achieving those goals. If you become addicted to these medications, we will refer you to get help and treatment with an addiction specialist to safely wean off medications causing safety concerns and/or addiction.

\_\_\_\_\_ I have read the above agreement and/or it has been explained to me by my provider or clinic staff. All of my questions and concerns have been answered/addressed to my satisfaction. I agree to comply with all terms outlined in this agreement and understand failure to do so may result in my termination from Comprehensive Spine and Pain/ Western Oklahoma Pain Specialists.

This agreement is entered on this \_\_\_\_\_ Day of \_\_\_\_\_, 2025

### 2025 UPDATE INFO

Patient Name \_\_\_\_\_

Current Address \_\_\_\_\_

Current Phone Number \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Emergency Contact Phone Number \_\_\_\_\_

Current Insurance \_\_\_\_\_

Patient (Signature): \_\_\_\_\_

Witnessed by: \_\_\_\_\_ Date: \_\_\_\_\_



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### Code of conduct

1. Must respect all Providers and staff at Western Oklahoma Pain Specialists /Comprehensive Spine and Pain. Any yelling, cursing or disrespectful behaviors to providers, staff or other patients may result in immediate termination.
2. Social Media posts slandering or talking negatively about the clinic or any providers will be grounds for termination.
3. Offensive comments made about others race, accent, religion, gender, Sexual orientation or other personal traits will result in termination
4. Physical or verbal threats and assaults toward staff or providers will result in termination.
5. Sexual or vulgar words or actions will result in termination.
6. Disrupting another patient's care or experience may result in termination.
7. I understand that if I am more than 15 minutes late to my appointment day/time, I will need to reschedule.
8. I understand all balances are due at time of service. I understand no appointments will be made unless my remaining balance is paid or payment plan has been established with the Practice Manager.
9. Multiple no shows and cancellations could result in termination from the clinic.
10. The taking of Photographs, video or voice recordings will be strictly prohibited by any patient, family member or visitor. Will be grounds for immediate dismissal.
11. Only Patients will be allowed in clinic rooms, with the exception of Procedure Patients will be allowed 1 visitor.

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Patient Name

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Date

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Signature



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### DISCLOSURE OF OWNERSHIP

In accordance with the Code of Federal Regulations Title 42, Volume 3, Section 489.3, this notice is provided to inform you that **Dr. Brian Blick** maintains an ownership interest in the following entity:

**Western Oklahoma Pain Specialists Lab**  
301 SW 80th St  
Oklahoma City, OK 73139

Dr. Brian Blick operates as an **independent private medical practice** and is **not directly employed by any major health organization** in Oklahoma. Many physicians in the area may be employed by or have investment ties to large healthcare institutions. Dr. Blick, however, remains committed to maintaining independence in his clinical decision-making.

#### Patient-Centered Referrals

Referrals made by Dr. Blick are based solely on your individual medical needs and established standards of care, with the goal of providing the highest quality health care. While Dr. Blick may refer you to the above-listed facility, **you are under no obligation to receive services there.**

#### Your Right to Choose

You have the **right to choose the provider or facility** for your healthcare services. Choosing a different provider will **not affect the quality of care you receive** from Dr. Blick or his staff. If you would like assistance or information about alternative providers or facilities, we are happy to provide it upon request.

**We welcome you as a patient and value our relationship with you.**

If you have any questions regarding this disclosure, please speak with Dr. Blick directly or a representative of Western Oklahoma Pain Specialists.

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### ACKNOWLEDGEMENT OF DISCLOSURE

By signing this form, you acknowledge that you have read, understood, and received this **Disclosure of Ownership.**

Print name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Witness: \_\_\_\_\_ Date: \_\_\_\_\_