



## **We Would like to Thank you for choosing**

Western Oklahoma Pain Specialists DBA Comprehensive Spine and Pain

We are an **Interventional Pain Practice**, focused on evidence-based procedures designed to improve function and quality of life. Our care team includes six highly trained physicians and advanced practice providers working together across multiple locations in Oklahoma to deliver coordinated, consistent care.

While medications may be part of treatment for some patients, they are **not our primary focus**. Instead, we emphasize advanced interventional therapies as the foundation of care, supported by individualized treatment plans.

What sets us apart is our unified approach—every provider operates from the same philosophy, ensuring you receive thoughtful, consistent, and goal-driven care at every visit.

Attached is your New Patient Paperwork.

**Please complete all pages. Even if you are only doing injections/procedures, we must have this paperwork in place.**

### **We Also need a copy of:**

- **Driver's License**
- **Medical Insurance (all cards if multiple)**
- **OMMA Card (if applicable)**



**Patient Demographic Information**

**Name:** Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ SSN: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Email: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Would you like to receive appointment reminders by text: \_\_\_\_\_ YES \_\_\_\_\_ NO  
May we leave a message regarding your appointment reminders: \_\_\_\_\_ YES \_\_\_\_\_ NO

Employer Name: \_\_\_\_\_ Employer Phone: \_\_\_\_\_  
Preferred Pharmacy: \_\_\_\_\_ Pharmacy Location: \_\_\_\_\_  
Pharmacy Phone: \_\_\_\_\_ Preferred Imaging Facility: \_\_\_\_\_

**Please select all that apply:**

**Race:** \_\_\_ American Indian or Alaska Native \_\_\_ Asian \_\_\_ Native Hawaiian or other Pacific Islander \_\_\_ White  
\_\_\_ Black or African American \_\_\_ Hispanic \_\_\_ Other Race \_\_\_ Other Pacific Islander \_\_\_ Declined to Answer

**Ethnicity:** \_\_\_ Hispanic or Latin \_\_\_ Not Hispanic or Latin \_\_\_ Declined to Answer

**Language:** \_\_\_ English \_\_\_ Spanish \_\_\_ Other, Please Specify: \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Phone#: \_\_\_\_\_ HIPAA Approved: \_\_\_\_\_ YES \_\_\_\_\_ NO

**Guarantor/Responsible Party (if Self, please leave blank)**

**Must be filled out if the patient is a Minor.**

**Divorced parents: The Parent that brings the child in for treatment is responsible for payment of the bill.**

Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ DOB: \_\_\_\_\_  
City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_ Employer: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**If you have Sooner Care and have primary insurance (other than Sooner Care) You MUST provide us with the primary insurance information. Your Sooner Care will not pay us until your primary insurance has processed the claim. If Sooner Care shows you have other primary insurance inaccurately, we will require that you provide us a valid termination date of that insurance and that you contact Sooner Care with that termination date.**



**Primary Insurance Information:(Present your insurance card)**

Insurance Company Name: \_\_\_\_\_  
Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_  
Insured Name(If not self): \_\_\_\_\_ DOB: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

**Secondary Insurance Information: (Present your insurance card)**

Insurance Company Name: \_\_\_\_\_  
Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_  
Insured Name(If not self): \_\_\_\_\_ DOB: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ PCP Phone: \_\_\_\_\_

**Referring Provider:** \_\_\_\_\_ Office#: \_\_\_\_\_

Other Treating Physicians, phone number and conditions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Reason For Visit (please select one): ( ) Procedure / Medication Management ( ) Procedure**

**Is this an injury related to a Motor Vehicle Accident?** \_\_\_ YES \_\_\_ NO

If yes, date of accident: \_\_\_\_\_

**Is this a Workers Compensation Injury?** \_\_\_ YES \_\_\_ NO

If yes, date of injury: \_\_\_\_\_ Date Pain Began: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Are you currently working? \_\_\_ YES \_\_\_ NO

If no, last day worked: \_\_\_\_\_ Current restrictions: \_\_\_\_\_

Adjusters Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Claim # \_\_\_\_\_

**Are you disabled:** \_\_\_ YES \_\_\_ NO

% of disability: \_\_\_\_\_

Permanent Restrictions: \_\_\_\_\_

**Primary Goals of Treatment:**

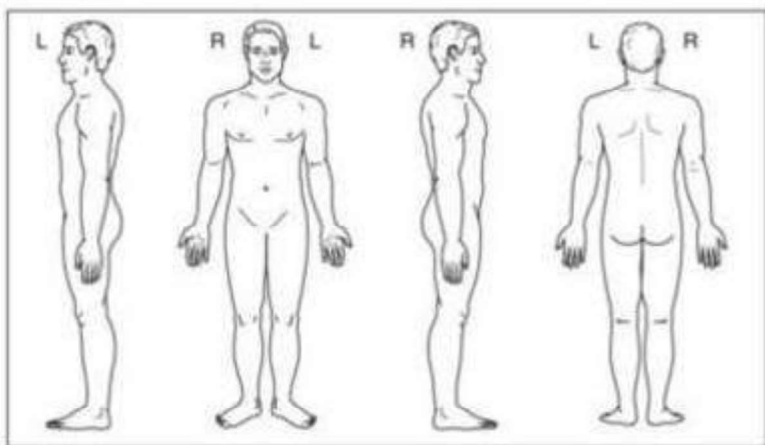
Return to Work: \_\_\_\_ Become more active: \_\_\_\_ Improve quality of life: \_\_\_\_ Other: \_\_\_\_\_

**What is your pain score today?**

Rate pain **TODAY** on a scale from 0 (no pain) to 10 (excruciating). \_\_\_\_\_

Rate pain as its worst on a scale from 0 (no pain) to 10 (excruciating). \_\_\_\_\_

Please **circle** the area of pain below:



Please **circle** all that apply:

Is your pain constant? YES OR NO

When did your pain start: \_\_\_\_\_

Is this due to a work injury: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Is this due to Motor Vehicle Accident or Personal Injury? \_\_\_\_\_ Date of injury \_\_\_\_\_

**Describe your pain, circle all that apply:**

Aching, Dull, Burning, Throbbing, Sharp, Stabbing, Shooting, Pressure, Squeezing, Tightness, Cramping, Spasming, Pins/Needles, Numbness, Tingling, Weakness

**What makes your pain worse, circle all that apply:** Lifting, Bending, Squatting, Stooping, Twisting, Sitting, Standing/Walking, Changing positions, Stretching, Manipulations/Chiropractor, Physical Therapy, TENS Unit, Acupuncture

**What makes your pain better, circle all that apply:** Ice, Heat, Massage, Rest, Lying down, Sitting, Standing/Walking, Changing positions, Stretching, Manipulations/Chiropractor, Physical Therapy, TENS Unit, Acupuncture

Have you ever participated in physical therapy for this problem? **YES** or **NO**, If YES, when? \_\_\_\_\_



Do you use any aids to better assist you when walking? \_\_\_\_\_

What medications have you tried for your pain? \_\_\_\_\_

Please list other previous treatments for your pain (i.e. Injections, nerve blocks, TENS units, etc.)  
\_\_\_\_\_

Do you have any bowel or bladder incontinence, fever chills? **YES** or **NO**

Do you currently have any allergies? \_\_\_\_\_

**PLEASE LIST: Medical Problems (Please circle all that apply)**

Hypertension                  Diabetes                  Stroke                  Coronary Artery Disease

COPD                          Sleep Apnea                  Seizures                  Atrial Fibrillation

Other: \_\_\_\_\_

**Surgical History:**

**Please list all spinal surgeries, fusions, laminectomy, etc.**

Surgery \_\_\_\_\_ Date \_\_\_\_\_ Surgeon: \_\_\_\_\_

Surgery \_\_\_\_\_ Date \_\_\_\_\_ Surgeon: \_\_\_\_\_

Surgery \_\_\_\_\_ Date \_\_\_\_\_ Surgeon: \_\_\_\_\_

Surgery \_\_\_\_\_ Date \_\_\_\_\_ Surgeon: \_\_\_\_\_

**Hospitalization History:**

Reason for Hospitalization: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Hospitalization: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Hospitalization: \_\_\_\_\_ Date: \_\_\_\_\_

**Are we authorized to view your online medication history? YES or NO**

If **yes**, please list current over the counter medication. If **no**, please list all medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any medication allergies? **YES** or **NO**. If yes, \_\_\_\_\_

Do you currently take any blood thinners or aspirin? **YES** or **NO** (if so what type?)

\_\_\_\_\_



**Social History: Please circle one**

Social status: Married      Single      Divorced      Widowed  
History of alcohol or drug abuse?    **YES or NO**  
Employment Status:    Employed      Self-Employed      Retired      Disabled  
Do you use medical marijuana and/or recreational?    **YES OR NO**

**Family History:**

Father: Medical Conditions: \_\_\_\_\_  
Mother: Medical Conditions: \_\_\_\_\_  
History of mental illness: \_\_\_\_\_

**Review of Symptoms: (CIRCLE ALL THAT APPLY)**

**Constitutional:** Fever, Fatigue, Unexplained Weight gain, Unexplained Weight loss, Generalized weakness

**HEENT:** Headache, Dizziness, Loss of vision, Corrective leanness, blurry vision, hearing loss, sinus problems, sore throat, hoarseness

**Respiratory:** Shortness of breath, Wheezing, Cough, Sleep apnea

**Cardiovascular:** Chest pain, Heartburn, Frequent constipation

**Genitourinary:** Infections, difficulty urinating, diminished ability to control urine, urinary infection

**Musculoskeletal:** Muscle weakness, Muscle pain or tenderness, Joint pain, Joint stiffness, Joint swelling

**Neurological:** Trouble walking, Balance, Fainting spells, Memory loss, Tremors

**Psychiatric:** Anxiety, Depression, Sleeping difficulty

**Endocrine:** Excessive thirst, Excessive urination

**Hematologic:** Anemia, Easy bruising or bleeding

**Skin:** Itching, Rashes, Sores



## **OFFICE POLICIES**

1. Co-pays and Patient Balances are due in full before you see the doctor. IF you are unable to pay your copay, we will reschedule your appointment. The only exception will be if you have spoken with the office manager prior to your appointment and made arrangements for payment. We accept cash, Visa and Mastercard. We will file claims with your insurance company for office visits and procedures; however, if your insurance does not pay within 90 days, you will be responsible for the bill. If it becomes necessary to send your account to an outside collection agency, their fees will be added to your balance.
2. To allow us to better serve all patients, we kindly ask that you provide **at least 24 hours' notice** if you need to cancel or reschedule an appointment. Appointments that are not canceled within this timeframe or are missed without notice will incur the following charges: **\$25** for clinic visits, **\$50** for late cancellations for scheduled procedures, **\$100** for missed procedure appointments.
3. Please limit phone calls to the office to 1 call and 1 message, multiple calls only delay the process. **Please allow 24-48 hours for a return call.**
4. In regard to prescription refills, please contact your pharmacy and they will fax a request to us. There are NO prescription refills after hours or on weekends or holidays. **NO EXCEPTIONS!**
5. If you require a copy of your medical records, you will be required to sign a release form and allow two weeks for copying. There is a \$25.00 charge to be paid in full at time of request. We will not fax records to anyone other than another physician who requests a signed release form.
6. Your children are welcome in the office but must always remain seated and quiet. IF they are disruptive or destructive, you will be asked to reschedule your appointment for a time when you will not have to bring them with you.
7. We only treat patients with Workers' Compensation Injuries with prior authorization from the Insurance carrier. You must also provide us with the adjuster's name, claim number and the correct billing information. If your claim is denied, you will be responsible for the entire bill.
8. It is your responsibility to notify us when your insurance changes **PRIOR** to any clinic visits and/or procedure. If you fail to do so and services are denied you will be responsible for the balance.

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

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



**Pain Patient’s Bill of Rights**

The following Office Policy of Western Oklahoma Pain Specialist, regarding the Patient’s Bill of Rights, particularly with respect to Pain Management. It is an exception that compliance with the Patient’s Bill of Rights can contribute to an effective program for the patient.

1. The patient has the right to considerate and respectful care
2. The patient has the right to obtain from the credentialed practitioner complete and current information concerning the:
  - a. Diagnosis;
  - b. Proposed treatment; and
  - c. Expected prognosis in terms that the patient may reasonably be expected to understand.
  - d. When it is not advisable to give such information to the patient, the information should be made available to an appropriate person (Medical Proxy) on the patient’s behalf.
3. The patient has the right to receive the necessary information for the medical decision-making and the granting of informed consent, from the treating credential practitioner prior to the start of any procedure or treatment. This information shall include at the minimum: the expected procedure or treatment, what alternatives exist if any, what are the likely risks from the procedure or treatment, what may occur if no treatment is undertaken, and the length of probable duration of incapacitation if any is expected.
4. The patient has the right to refuse any and all treatment to the extent permitted by law, and to be informed of any medical consequences of this action.
5. The patient has the right to every consideration of privacy concerning the medical care provided except when there is an imminent risk to the individual or others, or when the practitioner is ordered by court to breach confidentiality.
6. The patient has the right to be advised if the practitioner, agency, or facility proposes to engage in any form of human experimentation affecting the care of the treatment provided. The patient has the right to refuse to participate in research projects or to withdraw continued constant participation without repercussions.
7. The patient has the right to examine and receive an explanation of the bill for professional services rendered.

All pain management activities are to be provided with an overriding concern for the patient, and above all, the recognition of the patient’s dignity as a human being.

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

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

**CONSENT TO ACCESS EXTERNAL PRESCRIPTION HISTORY**

Please sign only after you have read and understand the following:

Patient Name (Please Print): \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_ whose signature appears below, authorize **Western Oklahoma Pain Specialists** and its affiliated providers to view the external prescription history via the RXHub services for the patient listed above.

I understand that a prescription history from multiple unaffiliated medical providers, Insurance companies, and pharmacy benefits managers may be viewable by the providers and staff of **Western Oklahoma Pain Specialists** and may include past prescriptions from several years ago.

MY SIGNATURE CERTIFIES THAT I HAVE READ, UNDERSTAND, AND AUTHORIZE THE ACCESS OF EXTERNAL PRESCRIPTION HISTORY.

Signature of Patient or Guardian	Date	Relationship to Patient
----------------------------------	------	-------------------------

WOPS Staff Witness	Date
--------------------	------



## 2026 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 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, Dr. Richard Fair, Dr. Michael Alvarado, Madeleine Hill, PA, Jessica Kearney, APRN, Jessica Kennemer, APRN, Brett Purvis, PA** 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**.

\_\_\_\_\_ 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** \_\_\_\_\_

\_\_\_\_\_ 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 plans (injections, physical therapy, referrals, etc.) I may be dismissed from care. It is my responsibility to reschedule missed or no-show appointments.**

\_\_\_\_\_ I **agree** to complete routine Creyos testing, as well as any additional testing required by law, as a condition of receiving pain medication. The **only exception** applies in cases where there is documented proof of a clinical diagnosis resulting in impaired eyesight.

\_\_\_\_\_ 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.

\_\_\_\_\_ 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



## 2026 Code of conduct

- A. 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.
- B. Social Media posts slandering or talking negatively about the clinic or any providers will be grounds for termination.
- C. Offensive comments made about others race, accent, religion, gender, Sexual orientation or other personal traits will result in termination
- D. Physical or verbal threats and assaults toward staff or providers will result in termination.
- E. Sexual or vulgar words or actions will result in termination.
- F. Disrupting another patient's care or experience may result in termination.
- G. I understand that if I am more than 15 minutes late to my appointment day/time, I will need to reschedule.
- H. 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.
- I. Multiple no shows and cancellations will result in termination from the clinic.
- J. 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.
- K. Only Patients will be allowed in clinic rooms, with the exception of Procedure Patients will be allowed 1 visitor.

---

**Patient Name**

**Date**

---

**Signature**



**Notification of Non-Covered or Not Medically Necessary Services Urine Drug Screening and Urine Drug Confirmations**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

To increase patient safety in the prescribing of controlled substances, **Western Oklahoma Pain Specialists** has instituted a urine drug testing policy that includes urine drug screening. The most basic level of screening is conducted frequently and these results are confirmed via advance laboratory confirmations under certain circumstances.

Please recognize that your insurance company may, or may not, cover the costs of urine drug screening. We feel strongly that this is a medically necessary test for responsible and safe prescribing of strong pain relievers. **We will not allow exceptions to our standard policy.**

The performance of these tests incurs significant cost upon the practice, and you will be held responsible for the costs should your insurance fall to reimburse for these services as being non-covered or not medically necessary.

\_\_\_\_\_  
**Patient Signature** **Date**

\*I have read your policy and agree to pay for these services outlined above that might be non-covered or not medically necessary by my insurance contract as indicated by my signature for the above date.

**Authorization for Release of Information to Family Members**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give the information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Western Oklahoma Pain Specialist to release my medical and/ or billing information to the following individual(s):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Patient Information:**

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

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

Effective **May 1, 2018**, Western Oklahoma Pain Specialist will no longer prescribe narcotic pain medication to those who concurrently use benzodiazepines or benzodiazepine-like medications. The US Food and Drug Administration (FDA) announced clinicians should not prescribe opioid pain medicines together with benzodiazepines (or the like) to **reduce the risk of overdose deaths**. Both classes of drugs are central nervous system (CNS) depressants, which can trigger shallow and/ or slowed breathing, coma and death, especially when combined. The FDA has spelled out these precautions in class-wide boxed warnings on labels



of opioid painkillers, benzodiazepines and other CNS depressants. The death toll has increased by 41% in the number of patients who were prescribed both an opioid painkiller and a benzodiazepine between 2002 and 2014, according to the FDA. Insurance companies and pharmacies have also made changes to their policies to reduce the risk by denying, covering or filling your medication if you're on opioid medication and benzodiazepines concurrently.

If you are currently being prescribed a benzodiazepine or benzodiazepine-like medication (see list below) you will have until your next follow-up and/or 2 months to discuss this change with your prescribing physician and taper accordingly. If you are unable to discontinue such medication, your pain medication will be tapered and/or discontinued at that time. **This is nonnegotiable.** If you have any additional questions regarding the above statement, please discuss this with your provider at your appointment.

**Benzodiazepines/Benzodiazepines-Like Medications to Avoid**

- Xanax (Alprazolam)
- Klonopin (Clonazepam)
- Restoril (Temazepam)
- Ativari (Lorazepam)
- Oxazepam
- Lunesta (eszopiclone)
- Clorazepate
- Halcion (Triazolam)
- Valium (Diazepam)
- Ambien (Zolpidem)

This list is not all-inclusive, if you have any concern regarding your medication please discuss it with the provider.

Brian E. Blick, M.D.  
Terrell Phillips, M.D.  
Madeleine Hill, PA

Luke Mosel, D.O.  
David Sharrah, M.D.  
Jessica Kennemer, APRN

Richard Fair, M.D.  
Michael Alvarado, M.D.  
Jessica Kearney, APRN

My signature below acknowledges that I have read and understand this policy.

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

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



## Disclosure of Ownership

Dr. Brian Blick, Dr. David Sharrah, Dr. Luke Mosel, Dr. Richard Fair, Dr. Michael Alvarado and Dr. Terrell Phillips operate as independent private medical practice and are 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. Each Dr. Blick, Dr. Sharrah, Dr. Mosel, Dr. Fair, Dr. Alvarado and Dr. Terrell Phillips, however, remains committed to maintaining independence in their clinical decision-making.

In compliance with the Code of Federal Regulations Title 42, Section 411.362(b)(3)(ii)(A), **Dr. Terrell Phillips** has invested in or has ownership in the following entities: **Oklahoma Center for Orthopedic & Multi-Specialty Surgery (OCOM)**.

In compliance with the Code of Federal Regulations Title 42, Section 411.362(b)(3)(ii)(A), **Dr. Brian Blick** has invested in or has ownership in the following entities: **Western Oklahoma Pain Specialists Lab, 301 SW 80th St. Oklahoma City, OK 73139**

In compliance with the Code of Federal Regulations Title 42, Section 411.362(b)(3)(ii)(A), **Dr. Brian Blick, Dr. David Sharrah, Dr. Luke Mosel, Dr. Richard Fair, Dr. Michael Alvarado and Brett Purvis, PA** maintain an ownership interest in the following entity: **OneCore Health 100 NE 85th St. Oklahoma City, OK 73114**

Dr. Brian Blick, Dr. David Sharrah, Dr. Luke Mosel, Dr. Richard Fair, Dr. Michael Alvarado, Dr. Terrell Phillips and Brett Purvis, PA make referrals based solely on each patient's individual medical needs and established standards of care, with the goal of providing high-quality, appropriate medical treatment.

You have the right to choose the provider and facility for your healthcare services. While your provider may recommend or refer you to a particular facility, you are under no obligation to receive services at that location. You may elect to receive care at an alternative facility or from another provider of your choosing.

Your decision to seek care at a different facility will not affect the quality of care you receive from your provider or their staff, and you will not be treated differently as a result of this choice. If you would like information or assistance regarding alternative providers or facilities, this information will be provided upon request.

We welcome you as a patient and value the trust you place in our providers and staff. If you have any questions regarding this disclosure, please speak directly with your provider or a representative of Comprehensive Spine and Pain.

### **ACKNOWLEDGEMENT OF DISCLOSURE**

By signing the acknowledgement of disclosure, you acknowledge that you have read and understand the Disclosure of Ownership

**Print name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

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

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

**Witness:** \_\_\_\_\_

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



### **Pain Disability Questionnaire**

The Pain Disability Questionnaire is used in Chapter 3 Pain (6th ed, 43-44) and Chapter 17 Spine (6th ed, 599-600). The format provided utilizes a centimeter scale to score, however the size in the Guides does not correspond with the same scale. An alternative approach (illustrated below) provides easily administered and scored numerical scales.

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

**Instructions:** These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?  
Work normally Unable to work at all  
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
2. Does your pain interfere with personal care (such as washing, dressing, etc)?  
Take care of myself completely Need help with all my personal care  
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
3. Does your pain interfere with your traveling?  
Travel anywhere I like Only travel to see doctors  
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
4. Does your pain affect your ability to sit or stand?  
No Problems Cannot sit/ stand at all  
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?  
No problems Cannot do at all  
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?  
No problems Cannot do at all  
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
7. Does your pain affect your ability to walk or run?  
No problems Cannot walk/run at all  
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
8. Has your income declined since your pain began?  
No decline Lost all income  
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
9. Do you have to take pain medication every day to control your pain?  
No medication needed On pain medication throughout the day  
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
10. Does your pain force you to see doctors much more often than before your pain began?  
Never see doctors See doctors weekly  
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?  
No problem Never see them  
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
12. Does your pain interfere with recreational activities and hobbies that are important to you?  
No interference Total interference  
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?  
Never need help Need help all the time  
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
14. Do you now feel more depressed, tense, or anxious than before your pain began?  
No depression/tension Severe depression/ tension  
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
15. Are the emotional problems caused by your pain that interfere with your family, social and or work activities?  
No problems Severe problems  
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Anagnostis C, Gatchal RJ, Mayer TG, The Pain Disability Questionnaire: A new Psychometrically Sound Measure for Chronic Musculoskeletal Disorders, *Spine* 2004; 29(20):2290-2302  
The guides Newsletter, March/April 2008



## Consent for Chronic Opioid Therapy

I understand that my physician is recommending opioid medicine, sometimes called narcotic analgesics, to treat my:

---

I understand that this medication is being recommended because my pain complaints are moderate to severe and other treatments have not sufficiently helped my pain. I understand that many medications can have interactions with opioids that can either increase or decrease their effect. Therefore, I have told my physician about all other medicines and treatments that I am receiving-and that I will promptly advise my physician if I start to take any new medications or have new treatments. Likewise, I have told my physician about my complete personal drug history and that of my family.

I have been informed by my physician that the initiation of a narcotic/opioid medication is a trial. Continuation of the medication is based on evidence of benefit to me from, associated side effects of, and compliance with instructions on usage of the medication. I have also been informed by my physician that continuation and any changes in dosage of the medication will be determined by pain relief, functional improvement, side effects, and adherence to usage restrictions. Lack of significant improvement, the development of adverse side effects, or other considerations may lead my physician to discontinue this treatment or to change dosage.

It has been explained to me that taking narcotic/opioid medications has certain risks associated with it. These include, but are not limited to, the following:

- Allergic reaction
- Overdose (which could result in harm or even death)
- Slowing of breathing rate
- Slowing of reflexes or reaction time
- Sleepiness, drowsiness, dizziness, and/or confusion
- Impaired judgment and inability to operate machines or drive motor vehicles
- Nausea, vomiting, and/or constipation
- Itching
- Physical dependence or tolerance to the pain-relieving properties of the medication. (This means that if my medication is stopped, reduced in dose, or rendered less effective by other medications I may be taking, I may experience runny nose, yawning, large pupils, goosebumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. These can be very painful but are generally not life-threatening.)
- Addiction
- Failure to provide pain relief
- Changes in sexual function (This is generally caused by reduced testosterone levels. Such reduced levels may affect mood, stamina, sexual desire and physical and sexual performance.)
- Changes in hormonal levels

In addition, use of these medications poses special risks to women who are pregnant. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetrician and this office to inform them. I have been advised that, should I carry a baby to delivery while taking this medication, the baby will be physically dependent upon opioids. I also understand that birth defects can occur whether or not the mother is on medication and there is always the possibility that my child will have a birth defect while I am taking an opioid. Furthermore, I recognize that the long-term consequence on a child's development who was exposed to opioids is not understood.

**Initials:** \_\_\_\_\_



### Consent for Chronic Opioid Therapy Continued

It has been explained to me that there are other treatments that do not involve use of narcotic/opioid medications. Having been informed of these risks and potential benefits of both medications and possible alternative treatments, I have freely consented to taking the narcotic/opioid medication.

I have been given the opportunity to ask any questions that I may have- and that any questions that I have raised have been discussed to my satisfaction.

I will take this/these medication(s) only as prescribed and I will not change the amount or dosing frequency without authorization from my physician. I understand that unauthorized changes may result in running out of medications early, and early refills will not be allowed. I also understand that if I do not take the medication correctly, I may have withdrawal reactions that may include stomach pain, sweating, anxiety, nausea, vomiting and general discomfort.

I will obtain all opioid prescriptions from my physician or, during his or her absence, by the cornering physician. Requests for pain medication from the on-call physician (nights and weekends) will not be honored. I will not request medications outside of normal business hours.

I hereby authorize my physician to discuss all diagnostic and treatment details of my condition with the pharmacists at the dispensing pharmacy.

**I will submit to random pill counts and urine drug tests as requested by my physician to monitor my treatment.** I understand that the presence of any unauthorized substance in my urine may prompt a referral for assessment of addiction or chemical dependency and could result in discontinuation of further opioid prescriptions. I also understand that failure to follow these rules may lead to a delay in medication or may no longer be treated by my physician after a 30-day period.

I will not share, sell or otherwise permit others to have access to these medications.

**I have read this form or have had it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines.**

**I UNDERSTAND AND AGREE THAT FAILURE TO ADHERE TO THESE POLICIES WILL BE CONSIDERED NONCOMPLIANCE AND MAY RESULT IN CESSATION OF OPIOID PRESCRIBING BY MY PHYSICIAN AND POSSIBLE DISMISSAL FROM THE CLINIC.**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_



## **DRUG ABUSE SCREENING TEST (DAST-10)**

*Using drugs can affect your health and may interact with medications you take. Please help us provide you with the best medical care by answering the questions below.*

Which Recreational Drug Have You Used In The Past?

*(check all that apply)*

Methamphetamines (speed, crystal)	Cocaine
Cannabis (marijuana, pot)	Narcotics (heroin, oxycodone, methadone)
Inhalants (paint thinner, aerosol, glue)	Hallucinogens (LSD, mushrooms)
Tranquilizers (valium)	Others:

1. Have you used drugs other than those required for medical reasons?  
**YES / NO**
2. Do you abuse more than one drug at a time?  
**YES / NO**
3. Are you unable to stop using drugs when you want?  
**YES / NO**
4. Have you ever had blackouts or flashbacks as a result of drug use?  
**YES / NO**
5. Do you ever feel bad or guilty about your drug use?  
**YES / NO**
6. Does your spouse (or parents) ever complain about your involvement with drugs?  
**YES / NO**
7. Have you neglected your family because of your use of drugs?  
**YES / NO**
8. Have you engaged in illegal activities in order to obtain drugs?  
**YES / NO**
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?  
**YES / NO**
10. Have you had medical problems as a result of drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?  
**YES / NO**



<b>Over the last 2 weeks, how often have you been bothered by any of the following problems?</b>	<b>Not at all</b>	<b>Several Days</b>	<b>More than half the days</b>	<b>Nearly every day</b>
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

**Total Score: 1-4 Minimal depression; 5-9 Mild depression; 10-14 Moderate depression; 15-19 Moderately severe depression; 20-27 Severe depression**

## **Advanced Directive**

- 1. I have one and will provide a copy
- 2. I currently do not have one but would like to fill one out and have it notarized
- 3. I do not have one nor am I interested



## **ALCOHOL AND TOBACCO INFORMATION**

### **Part I**

Did you have a drink containing alcohol in the past year?

No \_\_\_\_\_ (If no please move to tobacco section) YES \_\_\_\_\_ (If yes please answer questions below)

If yes, how often did you have a drink containing alcohol in the past year?

Monthly or less  Less than monthly  Daily or almost daily  Weekly  2-3 times a week

If yes, how many drinks did you have on a typical day when you were drinking in the past year?

1 or 2 drinks  3 or 4 drinks  5 or 6 drinks  7 or 9 drinks  10 or more drinks

### **Part II**

Nonsmoker (if you have never smoked you have completed this form)

Former smoker (please complete this section below)

Smoker (please complete this section below)

Former Smoker: How long has it been since you last smoked?

< 1 Month  1-3 Months  3-6 Months  6-12 Months

1-5 Years  5-10 years  > 10 Years

Current Smoker: How often do you smoke cigarettes/ E-cigarettes

Everyday  Some days, but not every day

How many cigarettes a day do you smoke?

5 or less  6-10  11-20  21-30  31 or more  E-Cigarettes

How soon after you wake up do you smoke your first cigarette:

Within 5 Minutes  6-30 Minutes  31-60 Minutes  60 Minutes

Are you interested in quitting?

Ready to quite  Thinking about quitting  Not ready to quit



**Functional Assessment Score**  
**RDQ (Roland-Morris Disability Questionnaire)**

When your neck or back hurts, you may find it difficult to do some of the things you normally do.

Remember, **only** mark the sentence if you are sure that it describes you today.

1. ( ) I stay at home most of the time because of the pain.
2. ( ) I change position frequently to help with my pain.
3. ( ) I walk more slowly than usual because of the pain.
4. ( ) Because of the pain, I am not doing any of the jobs that I usually do around the house.
5. ( ) Because of the pain, I use a handrail to get upstairs.
6. ( ) Because of the pain, I lie down to rest more often.
7. ( ) Because of the pain, I have to hold on to something to get out of a reclining chair.
8. ( ) Because of the pain, I ask other people to do things for me.
9. ( ) I get dressed more slowly than usual because of the pain.
10. ( ) I only stand up for short periods of time because of the pain.
11. ( ) Because of the pain, I try not to bend or kneel down.
12. ( ) I find it difficult to get out of a chair because of the pain.
13. ( ) My back or neck hurts most of the time.
14. ( ) I find it difficult to turn over in bed because of the pain.
15. ( ) My appetite is not very good because of the pain.
16. ( ) I have trouble putting on my socks (or stockings) because of the pain.
17. ( ) I only walk short distances because of the pain.
18. ( ) I sleep less because of the pain.
19. ( ) Because of the pain, I get dressed with help from someone else.
20. ( ) I sit down for most of the day because of the pain.
21. ( ) I avoid heavy jobs around the house because of the pain.
22. ( ) Because of the pain, I am more irritable and bad tempered with people.
23. ( ) Because of the pain, I go upstairs more slowly than usual.
24. ( ) I stay in bed most of the time because of the pain.



**ORT Assessment:** Please answer the following questions based on your sex assigned at birth. If you were assigned female at birth, complete the column labeled “Female.”

For the question regarding family history of substance abuse: Determine the correct column, does anyone in your family have a history of substance abuse and circle all options that apply.

Mark each box that applies	Female	Male
<b>Family history of substance abuse</b>		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
<b>Personal history of substance abuse</b>		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
<b>Age between 16—45 years</b>	1	1
<b>History of preadolescent sexual abuse</b>	3	0
<b>Psychological disease</b>		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
<b>Scoring totals</b>		



## **NOTICE OF PRIVACY POLICY IN REGARD TO HIPAA AND MEDICAL COLLECTIONS**

**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.** If you have any questions, don't hesitate to contact us at 405.601.4227.

It is the policy of Comprehensive Spine and Pain, Western Oklahoma Pain Specialists, and Blick MVA Collections LLC DBA ImpactMD Accident Care (collectively, "the Physician") to keep all of your medical and personal information confidential. We will only use or disclose your information for the following reasons:

**Treatment:** We will share your medical information with other medical providers who are involved in your care (including hospitals and clinics), to refer you for treatment, and to coordinate your care with others.

**Payment and/or authorization of a procedure:** We may use and disclose protected health information (PHI) when it is needed to receive payment for services provided to you. For example, if your insurance requires certain dictations or office notes to determine if a procedure is deemed necessary.

**Health care operations:** We will use and disclose PHI when it is needed to make sure we are providing you with good service. For instance, we may review your records in order to make certain quality services were given.

The Physician may contact you to provide appointment reminders.

Other uses or disclosures of your PHI that may occur include:

- If you have given us permission in writing to release part or all of your information.
- When ordered to do so by a valid court order.
- When business associates of the physician sign agreement to protect your privacy.
- When required by state law. For instance, when reporting injuries and disease as required by the Public Health Codes or to prevent the spread of disease such as tuberculosis (TB).
- We can share your information with anyone as necessary; consistent with Oklahoma Law and the Oklahoma State Department of Health's policies and procedures, if we feel there is imminent danger. For example, we will release the minimum information necessary if we believe it will prevent or lessen a serious and imminent threat to the health and safety of a person or the public.

**Emergency Coordination:** We will share your medical information with other medical providers who are involved in your care to coordinate your care with others (such as emergency relief workers or others who can help in finding you appropriate health services).

### **Any Other Use or Disclosure of Your PHI Requires Your Written Authorization:**

Under any circumstance other than those listed above, the Physician will ask for your written authorization before we use or disclose your PHI. Specifically, the Physician must obtain your written authorization for the use and disclosure of psychotherapy notes, marketing, and the sale of PHI. The Physician will not sell PHI without your written authorization. You can later cancel your authorization in writing and we will not disclose your PHI after we receive your cancellation, except for disclosure which we process before we received your cancellation.

### **Your Rights:**

You have the right to:

- Receive of persons or organizations, other than those listed above, to whom we release your information
- Request limits on how your information is used or disclosed; however, we are not required to agree to those limits unless you pay out of pocket in full for a service. If you pay out of pocket in full for a service and you request we not share information for that service with your insurance company we will honor your request.
- Ask that we not contact you at home.
- Inspect and copy your medical records except in the cases involving certain psychotherapy notes.
- Amend incorrect information in your medical record.
- Revoke your written permission for release of information.
- Receive notification if your unsecured health information is breached.
- Receive a paper copy of this privacy notice.

### **Our responsibilities:**

Federal law requires that the Physician and its entities and affiliates to:

- Maintain the confidentiality of your protected health information.
- Provide you with a copy of this notice.
- Abide by the terms of this notice.
- Only change this notice as permitted by federal rules.
- Provide you with a way to file complaints regarding privacy issues.



### HIPAA Signature Page

#### Acknowledgment of Receipt of "Notice of Privacy Practice"

I acknowledge that ImpactMD Accident Care, Comprehensive Spine and Pain, and/or Western Oklahoma Pain Specialists have given me a copy of a 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.

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:** \_\_\_\_\_



## HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information. This form is for use when authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### I. My Authorization

I authorize Comprehensive Spine and Pain, its agents, employees, and affiliates to use or disclose the following health information.

- All of my health information  
 My health information for the following condition(s): \_\_\_\_\_  
 I do not authorize disclosure of my health information

Comprehensive Spine and Pain may disclose this health information to the following recipient(s), please include medical providers, family, and friends:

Name, relationship and/or organization \_\_\_\_\_

---

### II. My Rights

- I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made. I may not be able to revoke this authorization if its purpose was to obtain insurance.
- I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.
- I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

DISCLAIMER: If you are signing this authorization electronically, you agree that your electronic signature is the legal equivalent of your physical signature on this document.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

If the patient is a minor or unable to sign please complete the following:

- Patient is a minor: \_\_\_\_\_ years of age  
 Patient is unable to sign because: \_\_\_\_\_

DISCLAIMER: If you are signing this authorization electronically, you agree that your electronic signature is the legal equivalent of your physical signature on this document.

Signature of Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_

### III. Additional Consent for Certain Conditions



This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases (including, but not limited to Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS)), abortion, or mental health treatment.** Separate consent must be given before this information can be released.

- I consent to have the above information released.
- I do not consent to have the above information released.

DISCLAIMER: If you are signing this authorization electronically, you agree that your electronic signature is the legal equivalent of your physical signature on this document.

Signature of Patient or Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_