Cardinal Pain Center P.A.

Conquer Pain ... Live Again

VOTED BEST DOCTORS IN DALLAS
BY D MAGAZINE
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Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care. Your clear understanding of our practice financial and no show/cancellation policy is important to our professional relationship. The following information outlines your responsibility related to payment and appointment reservation for professional services. I order to keep healthcare cost to an absolute minimum, we have adopted the following policies.

1. At each visit, we will verify your benefits with your insurance company. It is ultimately your responsibility to know whether your plan is in network for our practice. The patient needs to be aware what their plan benefits are and what is covered.
2. At each visit we will require a payment of the following
a. Any plan copays
b. Any previous balances
c. Current deductibles, we will inform you if any
d. Non- covered or out of network services.
3. No show appointments:
a. Effective January 1, 2019 and established patient who fails to show or cancel/reschedule and has not contact our office 24 hours in advance will be subjected to a $25.00 fee
b. After 3 consecutive no shows the patient may be subjected to dismissal from the practice and will not be rescheduled.
c. The No Show fee is charged to the patient and will not be covered by insurance. Payment must be taken care of by or on next appointment.

We understand emergencies, and unexpected things do come up. Please keep in mind that you are able to leave a detailed voicemail with cancellation notice.

INFORMED CONSENT AND PAIN MANAGEMENT AS REQUIRED BY THE TEXAS MEDICAL BOARD

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the

recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY:
I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS

INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform

the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from your care.

For female patients only:

To the best of my knowledge I am NOT pregnant.

If I am not pregnant, I will use appropriate contraception/birth control during my course of

treatment. I accept that it is MY responsibility to inform my physician immediately if I become

pregnant.

If am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/ fetus !baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE

FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the

opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING: That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the medication(s) may be discontinued.
- I will disclose to my physician all medication(s) that I take at any time, prescribed by any physician.
- I will use the medication(s) exactly as directed by my physician.
- I agree not to share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will not allow or assist in the misuse/diversion of my medication; nor will I give or sell them to anyone else.
- All medication(s) must be obtained at one pharmacy, where possible. Should the need arise

to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.

- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. If either are lost or stolen, they may NOT BE REPLACED.
- Refill(s) will not be ordered before the scheduled refill date. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) only from ONE physician unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then my physician may try alternative medication(s) or may taper me off all medication(s). I will not hold my physician liable for problems caused by the discontinuance of medication(s).
- I agree to submit to urine and/or blood screens to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an treatment center or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral Therapy/psychotherapy.

• I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program recommended by my physician to achieve increased function and improved quality of life.

• I agree that I shall inform any doctor who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.

• I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

• I must take the medication(s) as instructed by my physician. Any unauthorized increase in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.

• I must keep all follow-up appointments as recommended by my physician or my treatment may be discontinued.

I certify and agree to the following:

1) I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in fill possession of my faculties and not under the influence of any substance that might impair my judgment.

2) I have never been involved in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

3) No guarantee or assurance has been made as to the results that may be obtained from

chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION (HIPPA) ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

CARDINAL PAIN CENTER is a healthcare entity that is issuing this Notice of Privacy Practices about the information we share in common and your legal rights and our common duties with respect to your health information.

OUR PLEDGE TO YOU:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care, bill for your care, and comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether made by our staff and authorized trainees, or by your personal doctor. This notice tells you about the ways in which Cardinal Pain Center may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe our obligations regarding the use and disclosure of your health information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

Cardinal Pain Center doctors, nurses, pharmacists, laboratory technicians, and other health care professionals may use health information about you to provide you with health care treatment or services. We may also disclose health information about you to others who are involved in taking care of you. For example, we may send health information about you to a specialist as part of a referral.

Cardinal may use and disclose health information about you to obtain payment for the treatment and services you receive from us. For example, we may send billing information to your insurance company or Medicare. We may also tell your insurance company about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. Cardinal may send you a statement of your account if payment is due from you. We may send the guarantor (responsible party for payment) monthly statements for charges for all patient's under that guarantor.

Cardinal may use and disclose health information about you to Support our health care operations. For example, we may use health information to review the treatment and services and to evaluate the performance of our staff in caring for you. We may combine health information about many patients to decide what additional services we should offer. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

We may disclose information to notify a family member or other person responsible for your care about your condition, status, and location.

If you are admitted and unless you tell us otherwise, we may provide your name, location in the hospital, and your general condition (good, fair, etc.) for information to be included in a patient directory and

make this information available to anyone who asks for you by name.

We may use and disclose health information to contact You for an appointmed reminder, to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you, or to contact you about supporting our fund raising efforts.

Subject to certain requirements, we may use or disclose health information about you without your prior authorization for other reasons:

We may give out health information about you for public health purposes; to report abuse or neglect; for health oversight reviews; in research studies; for funeral arrangements and organ donation; in response to special law enforcement requests, valid judicial or administrative orders, or for authorized national security and intelligence activities; for workers' compensation purposes; to avert a serious threat to your health or safety or those of the public or another person; and when required by law. If you are or were a member of the armed forces, we may release information about you as required by military command authorities or the Department of Veterans Affairs. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official.

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing your health information. You may revoke this authorization for any subsequent disclosures by notifying us in writing.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.

You have the right to request in writing that you inspect and obtain a copy of the health information that we use to make decisions about your care. We may charge a fee for the costs of copying, mailing or other

supplies and services associated with your request. If we deny your request to inspect or obtain a copy in certain limited circumstances, you may request that the denial be reviewed. Another licensed health care professional chosen by Cardinal Pain will review your request and the denial and we will comply with the outcome of that review.

If you believe that health information we have about you is incorrect or incomplete, you may make a written request to ask us to amend information. The request should state the reason for the amendment and specific information to be amended. The amendment must be limited to one page. Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously noted.

We may deny your request for an amendment if the information to be amended was not created by us, is no longer maintained by us, is not part of the information which you would be permitted to inspect and copy; or is accurate and complete. We will notify you if we deny your request for amendment and you may appeal, in writing, our decision. Any statements of disagreement or rebuttal will be linked to your health information and made a part of any subsequent disclosure we make of such information.

You have the right to make a written request for a list of disclosures we have made of your health information, except for uses and disclosures for treatment, payment, and health care operations, as previously described, and those for which you have authorized disclosure. Your request must state a time period which may not be longer than six years and may not include date April 14, 2003. We will not charge you for the first list you request within a 12-month period, additional requests will be charged according to our cost for producing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

You have the right to request a restriction on the health information we use or disclose about you for treatment, payment, or health care operations. There may be risks associated with such restrictions and we may ask you to acknowledge these risks in writing for certain requests you may make. We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

You have the right to request, in writing without requiring you to state a reason, that confidential communications with you be made in an alternative manner or location. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

WRITTEN REQUESTS

If you have any questions about this notice, please contact: Cardinal Pain COPIES OF NOTICE AND CHANGES
You have the right to obtain a paper copy of this notice at any time.
We reserve the right to change this notice, and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future.

COMPLAINTS

If you are concerned that your privacy rights may have been violated or you disagree with a decision we make about your health information, you may contact us.. You may also send a written complaint to the U.S. Department of Health and Human Services. We can provide you the address.

Under no circumstances will we ever ask you to waive your rights under this notice or retaliate against you in any manner for filing a complaint.

GUIDELINES FOR CHRONIC NARCOTIC ADMINISTRATION

The successful management of chronic pain involves many modalities including, but not limited to, physical therapy, surgical consultation, injection therapy, stress reduction, biofeedback, and oral medications. Occasionally, upon the mutual agreement of the patient and the pain management physician, it may be necessary to institute long-term opiate administration to achieve satisfactory pain control. The following are guidelines that will be helpful in managing the long-term administration of narcotic medications. Prior to initiating this therapy the patient will read the following guidelines, and discuss them thoroughly with the provider.

- **Patient agrees to fill prescription medications at one pharmacy only.** This pharmacy will be responsible for all medications prescribed during treatment.
- **Pain medication prescriptions will be obtained only from the pain clinic office.** "Doctor shopping" for additional pain medications from other physicians is discouraged, and if this occurs will jeopardize the physician/patient relationship. Patients must make an office visit for their pain medication refills-no refills are done over the phone or fax.
- **Please take only the amount of medication prescribed.** Narcotic analgesics will hopefully make your pain more tolerable, but they should not be used to relieve stress or to promote sleep. If your pain worsens or if there is a change in your symptoms, please make an appointment to be seen in the office.
- ***Lost or misplaced medications or their prescriptions will <u>not</u> be refilled at an early date.*** After hours or weekend calls for refills are not emergencies and won't be responded to by the on-call provider.
- **Emergency room visits for pain medication are discouraged.** The emergency room is an inefficient way to achieve pain reduction and may involve a long wait and the risk that no medication will be dispensed. It is unlikely that the pain management physician will be available for patients in the emergency room.
- **Patient also agrees to continue with other modalities of chronic pain management** as deemed appropriate by

the referring physician and the pain clinic physician. This will most likely include physical therapy, biofeedback, relaxation therapy, counseling, and other methods to help handle the stress of chronic pain.

- **Patient authorizes Cardinal Pain Management to obtain information** concerning medications prescribed, amount, and frequency from pharmacies and other physician offices.
- **Patient agrees to have a random drug screen** when ordered by a provider, the results of which might cause termination from the practice .**Patient reports to any Cardinal Pain practitioner any problems with memory disturbance or problems in remembering how and when to take their medications.**

NARCOTIC THERAPY – SIDE EFFECTS, RISKS AND COMPLICATIONS

The patient understands that narcotic analgesics may result in physical dependence that ultimately may require slow weaning once the pain condition improves. Immediate discontinuation of this medication is not advised. Tolerance to the medication may develop after long-term usage which means that ultimately these medications may become less effective. Other side effects may include...

- Respiratory depression resulting in respiratory arrest and/or death, as well as resultant cardiac arrest &/or death.
- Tolerance and/or physical dependence necessitating tapered discontinuation of the medications.
- Withdrawal phenomenon with abrupt discontinuation of the medication causing significant side effects such as palpitations, diaphoresis, elevated pulse and blood pressure.
- Disorientation, resulting in falls and resultant significant injury.
- Constipation and bowel obstruction, and even bowel perforation, possibly requiring surgical intervention and potentially resulting in ischemic (dead) bowel, sepsis and death.
- Allergic and/or anaphylactic reactions to the medications resulting in hypotension, tachycardia, arrhythmias, respiratory or cardiac arrest, and death.

- Potentiation of other sedative medications causing additive and/or synergistic interactions and greater than expected or enhanced side-effects

PRECAUTIONS

(1) Patients taking anticoagulants are at particularly high risk since any kind of trauma (falls, etc) could result in life-threatening hemorrhage, intra-cranial bleeding, and death).
(2) Extremes of age. The very young and the elderly may exhibit marked and dramatic side effects from narcotic medications, even in low doses.
(3) Patients with other significant medical problems (heart or lung disease, other) are at increased risk for complications.
(4) Patients taking sedative medications or central nervous system depressants should use narcotics sparingly if absolutely necessary and in reduced doses due to additive and synergistic effects.
(5) It is especially important to keep your medications in a secure location, and preferably, under lock and key to avoid others (including children) from obtaining access to these potentially deadly substances.
(6) Narcotic analgesics should not be used during pregnancy. By signing this, I acknowledge that I am not pregnant and that it is my responsibility to notify my physician if I am planning a pregnancy or if I become pregnant.

WHAT NOT TO DO WHILE TAKING NARCOTICS

- Any kind of activity where judgement is required - i.e. signing important documents, caring for the sick, the elderly, or the very young.
- Driving or operating machinery
- Working in high-risk areas (ie, construction sites, elevated work sites, working with power tools, etc)
    - Drinking alcohol or using recreational drugs is prohibited while on narcotics due to potent and unpredictable enhancement of central nervous system depression of these substances when taken together.

All questions were answered to the patient's satisfaction. The patient was encouraged to ask any additional questions or seek clarification for anything which was not clear in the

guidelines. Additionally, non-narcotic management treatment options were offered. These were declined by the patient.

I have read the above guidelines and will make every effort to follow these guidelines during my chronic pain management.

MEDICATION POLICY

In order to run our practice as efficiently as possible we would like to explain our medication policy:

- We do not refill medications over the phone or by fax. Please come to your appointment with all of your pain medications in the actual bottles. Please remember, the medications we prescribe should be taken only as directed, and should last until your next appointment with our office.

- **It is our policy not to provide or refill medications early. If medications are taken more often than prescribed, or are lost or stolen, they cannot be replaced.**

- If you have a change in your pain levels, we ask that you call immediately to make an appointment with our office. You will then receive an individual consultation as soon as our schedule will allow. These visits help us to closely monitor your condition and your response to medications.

- We ask that our medication refill telephone line be used sparingly. Spending time answering pharmacy requests prevents us from caring for patients in the office.

- Remember that your pharmacist is well-educated regarding medications, and is a valuable resource for information.

- Due to recent changes in CDC guidelines we are not able to prescribe opioid medication if you are on Benzodiazepines. You will be asked to be weaned off

or get a letter from psychiatrist stating reason you must be on medication.

- We are not able to provide opioid medication if it is more than 90 morphine milligram equivalents (MME) per CDC guidelines.

Thank you very much for reviewing this policy.