























**Office 1** : 6720A Rockledge Dr, #500 • Bethesda, MD 20817 • Tel: (301) 530-7303 • Fax: (301) 530-7312  
**Office 2** : 2112 F Street, NW #802A • Washington, DC 20037 • Tel. (202) 775-7246 • Fax: (202) 775-2345

**Payment:** We will use and disclose your health information for payment purposes. For example, we will use your health information to prepare and submit bills and we may need to submit information to your insurance company to obtain authorization prior to providing certain types of treatment.

**Health Care Operations:** We will use and disclose your health information to conduct our standard internal operations. For example, we may use or disclose your health information to conduct quality assessment and improvement activities and for business management and other general administrative activities.

**Special Uses:** We may use your information to contact you with appointment reminders or to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Other Uses or Disclosures:** We may use or disclose your health information for the following purposes without your consent and, in some cases, we may be required to do so:

-Required by Law: We may be required to disclose your health information to certain legal authorities if it relates to suspected crimes, abuse, neglect, or similar injuries or events.

-Public Health Activities: We may be required to disclose your health information to public health officials for purposes of collecting vital statistics, information related to disease control, federal regulation of food and drug quality and safety, etc.

-Health Oversight: We may be required to disclose your health information to certain regulatory authorities for purposes of oversight the health care system, government benefits programs, and regulatory compliance investigations or audits.

-Judicial and Administrative Proceedings: We may disclose your health information in response to a lawful subpoena, discovery request, or court order.

-Deaths: We may disclose information relating to deaths to coroners, medical examiners, funeral directors, or organ donation agencies.

-Serious Threat to Health or Safety: We may disclose your health information if necessary to prevent or lessen a serious threat to the health or safety of a person or the public.

-Military and Special Government Forces: If you are a member of the armed forces, we may disclose your information to appropriate military command authorities at their request. Additionally, we may disclose information to a correctional institution or law enforcement official as required for the care, health and safety of inmates and/or employees of the correctional institution. -Research: In appropriate situations, we may disclose your health information for approved medical research.

-Workers' Compensation: We may disclose your health information in compliance with workers' compensation laws or similar programs.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you decide to authorize the use or disclosure of your health information, you may later revoke such authorization, as provided by 45 CFR § 164.508(b)(5), to prevent the future use or disclosure of your health information in this way.



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Maryland Specific Requirements. In the state of Maryland, you have the following additional rights with respect to your health information:

(1) Your health information may not be disclosed except to the extent that the disclosure is consistent with the authorized purposes for which the information was first obtained. The person or entity to which we disclose your health information may not further disclose that medical information except in accordance with a new written authorization for you, or as specifically required or permitted by law.

(2) If you have requested a restriction on the uses and disclosures of your health information, and we have granted such request, we are required to communicate those restrictions and/or limitations to the person or entity to which we disclose your health information.

Maryland law also limits disclosures of your health information in ways that would otherwise be permitted under federal law. In the situations described below, we will disclose your medical information as follows.

(1) Your health information may be disclosed to other providers of health care, health care service plans, contractors, or other healthcare professionals or facilities for purposes of diagnosis or treatment of the patient. This includes, in an emergency situation, the communication of patient information by radio transmission or other means between emergency medical personnel at the scene of an emergency, or in an emergency medical transport vehicle, and emergency medical personnel at a licensed health facility.

(2) Your health information may be disclosed to an insurer, employer, health care service plan, hospital service plan, employee benefit plan, governmental authority, contractor, or any other person or entity responsible for paying for health care services rendered to you., to the extent necessary to allow responsibility for payment to be determined and payment to be made. If you are, by reason of a comatose or other disabling medical condition, unable to consent to the disclosure of medical information and no other arrangements have been made to pay for the health care services being rendered, your health information may be disclosed to a governmental authority to the extent necessary to determine that you are eligible for, and to obtain, payment under a governmental program for health care services provided to the patient

(3) Your health information may be disclosed to a person or entity that provides billing, claims management, medical data processing, or other administrative services for providers or health care or health care service plans. However, any health information so disclosed shall not be further disclosed by the recipient in a way that would violate state law.

(4) Your health information may be disclosed to organized committees and agents of professional societies or of medical staffs of licensed hospitals, licensed health care service plans, professional standards review organizations, independent medical review organizations and their selected reviewers, utilization and quality control peer review organizations, contractors, or persons or organizations insuring, responsible for, or defending professional liability that a provider may incur, if the committees, agents, health care services plans, organizations, reviewers, contractors, or persons are engaged in reviewing the competence or qualifications of healthcare professionals or in reviewing health care services with respect to medical necessity, level of care, quality of care, or justification of charges.



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(5) Your health information may be reviewed reviewed by a private or public body responsible for licensing and/or accrediting our facility. However, no patient-identifying medical information may be removed from our premises except as expressly permitted or required elsewhere by law, nor shall your health information be further disclosed by the recipient in a way that would violate state law.

(6) Unless we are notified in writing of an agreement to the contrary, your health information may be disclosed to a sponsor, insurer, or administrator of a group or individual insured or uninsured plan or policy that you seek coverage by or benefits from, if the health information was created by us as the results of services conducted at the specific prior written request and expense of the sponsor, insurer, or administrator for the purpose of evaluating the application for coverage of benefits.

(7) Your health information may be disclosed to the health care service plans in which we contract for the purpose of administering the health care service plan. Your health information shall not otherwise be disclosed by a health care service plan.

(8) Health information may be disclosed to an organ procurement organization or a tissue bank processing the tissue of a decedent for transplantation into the body of another person, but only with respect to the donating decedent, for the purpose of aiding the transplant.

(9) Your health information may be disclosed to a third party for purposes of encoding, encrypting, or otherwise anonymizing data. However, no health information so disclosed shall be further disclosed by the recipient in a way that would violate state law, including the unauthorized manipulation of coded or encrypted medical information that reveals individually identifiable medical information.

#### Your Health Information Rights:

Although your health record is the physical property of Pain Management Institute, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your health information for treatment, payment, health care operations, or other permitted purposes, as provided by 45 § CFR 164.522(a). Please note, however, that we are not legally required to agree to all requested restrictions.
- Receive confidential communications of your health information, as provided by 45 § CFR 164.522(b).
- Inspect and copy your health record as provided by 45 CFR § 164.524.
- Amend your health record as provided in 45 CFR § 164.526.
- Receive an accounting of disclosures of your health information as provided in 45 CFR § 164.528.
- Obtain a paper copy of this health notice of information practices upon request.

#### Our Responsibilities

Pain Management Institute is required to:



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-Maintain the privacy of your health information. -Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. -Abide by the terms of the notice of health information practices currently in effect.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have provided to us.

**For More Information or to Report a Problem:**

If you believe your privacy right has been violated, you can file a complaint as above with the Office for Civil Rights, U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint. The address for the OCR is listed below:

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

**Patient/Person Authorized to Consent:**

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Signature

Date

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Print Name



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## PATIENT FINANCIAL TERMS AND CONDITIONS

We are committed to providing you with the best possible care and service. In order to achieve this, we need you to provide us with all relevant insurance information at the time of service. If we are a participating provider with your insurance company, we will be happy to process your insurance claim forms for reimbursement. However, it is your obligation to understand the terms and conditions of your insurance regarding medical procedures and treatments that are covered under your plan, you copay, coinsurance, deductible, and whether a referral form is required for services. If you are a self-paying patient, payment is **DUE** at the time of service in the form of cash or credit card. If we are not a participating provider with your insurance company, it is your responsibility to assure that we are properly and promptly reimbursed for our services. In the event that your insurance company does not cover medical procedures that you have received, you are ultimately responsible for all charges for these services.

PLEASE NOTE, IF WE ARE **NOT** A PARTICIPATING PROVIDER WITH YOUR INSURANCE COMPANY, YOU MUST REALIZE THE FOLLOWING:

1. Your insurance is a contract with you and the insurance company. We are not a party to that contract and therefore not bound by its terms and conditions.
2. We are not bound to the fee payment structure of your insurance company. You are responsible for whatever portion of our charges your insurance does not pay.
3. Not all services are covered benefits in all contracts. Some insurance companies will not cover certain services. These charges are your responsibility.

All accounts are due in 30 days after the insurance companies have paid. Interest in the amount of 1.5% per month will added until the balance is paid. There will be a \$40.00 service charge for any check(s) which is/are dishonored by the bank. If your balance is unpaid after 90 days, it will be considered delinquent and will be submitted to our attorney for collections. You would then be responsible for collection cost, interest, court costs, attorney fees, and consequential expenses related to the reporting of the account to the credit bureaus.

Please note that if you are having a procedure done in our ambulatory surgery center, Capitol Surgical Center, there will be 2 separate bills submitted to your insurance company. One is for the professional fee (doctor's fee) from Pain Management Institute. The other will be a facility fee from Capitol Surgical Center. The facility fee covers the cost of nurses, technicians, x-ray, disposables, and medications used in performing the procedure.

Please indicate your understanding and acceptance of this agreement by signing below.

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

\_\_\_\_\_  
Date



### **Insurance Authorization and Assignment Form**

All professional services rendered are charged to the patient. If we do not accept your insurance plan, the necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees and it is customary to pay when services are rendered unless other arrangements have been made in advance with our facility. You are required to cover your co-insurance and/or deductible when services are rendered. It is the responsibility of the patient to secure the necessary referrals from his/her primary care physician. If you do not have the necessary referral at the time of your visit, the charges for the service rendered will be your responsibility and is expected to be paid at the time of your visit.

#### **Patient Acknowledgement:**

*I hereby authorize Pain Management Institute to render services related to the visit for which I am scheduled and have consented to, and to furnish all information to the insurance carrier / payor concerning my illness and treatments. I hereby assign all insurance or third-party carrier payments to Pain Management Institute for medical services rendered to myself or my dependents. I understand that I am responsible for any amount that is not a covered service under my insurance.*

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PATIENT NAME

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DATE

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SIGNATURE



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### CONTROLLED SUBSTANCE AGREEMENT

In the event that my consultation/procedure today results in the doctor prescribing any controlled substances. I promise to adhere to the following:

1. I understand that there are risks associated with the use of prescribed medications such as dependence, addiction, personality changes, sleep disorder, constipation, appetite changes, loss of coordination, and changes in sexual desire and performance. I will therefore use the substances only within the parameters given to me by the Pain Management Institute physicians.
2. I will not receive replacements for lost or stolen medications.
3. I will not give these medications to other people under any circumstances.
4. I will receive controlled substances ONLY from the Pain Management Institute unless, arrangements have been made with my other physician and Pain Management Institute is aware of these arrangements. Any violation of this rule will result in the discontinuation of treatment.
5. I will not expect to receive additional medication before my next scheduled refill, even if my prescription runs out.
6. If it appears to the physician that my daily functioning and quality of life are not benefiting from treatment with the controlled substance, I will gradually taper off my medication as directed by the physician. I will not hold any member of the Pain Management Institute group liable for problems caused by the discontinuance of controlled substances.
7. I agree to submit to urine, oral, and/or blood screening to detect the use of non-prescribed medications at any time. Medication interactions can increase the risk associated with narcotics.
8. I will review and follow the instructions provided with my medication and by my pharmacist. I understand that my medication may impair my abilities to perform certain activities, such as driving and operating equipment, and that I should avoid such activities, if impaired.
9. I recognize that my chronic pain represents a complex problem that may benefit from physical therapy, psychotherapy, and behavioral medicine strategies. I also recognize that my participation in the management of pain is extremely important. I agree to actively participate in all aspects of the Pain Management Program to maximize my level of functioning and to increase my ability to cope with my condition.
10. Under no circumstance will there be any altering of any prescription.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date



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

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

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

**SOAPP®-R**

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. How often have you felt a need for higher doses of medication to treat your pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. How often have you felt impatient with your doctors?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. How often have you felt that things are just too overwhelming that you can't handle them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. How often is there tension in the home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. How often have you counted pain pills to see how many are remaining?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. How often have you been concerned that people will judge you for taking pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. How often do you feel bored?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. How often have you taken more pain medication than you were supposed to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. How often have you worried about being left alone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. How often have you felt a craving for medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. How often have others expressed concern over your use of medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	<b>Never</b>	<b>Seldom</b>	<b>Sometimes</b>	<b>Often</b>	<b>Very Often</b>
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. How often have others told you that you had a bad temper?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. How often have you felt consumed by the need to get pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. How often have you run out of pain medication early?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. How often have others kept you from getting what you deserve?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. How often, in your lifetime, have you had legal problems or been arrested?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. How often have you attended an AA or NA meeting?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. How often have you been in an argument that was so out of control that someone got hurt?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. How often have you been sexually abused?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. How often have others suggested that you have a drug or alcohol problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. How often have you had to borrow pain medications from your family or friends?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. How often have you been treated for an alcohol or drug problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*Please include any additional information you wish about the above answers.  
Thank you.*

Nombre: \_\_\_\_\_

Fecha: \_\_\_\_\_

Fecha De Nacimiento: \_\_\_\_\_

**SOAPP®-R**

Las siguientes son algunas preguntas hechas a pacientes. Algunos de estos pacientes toman medicamentos para el dolor. Otros aún no toman medicamentos para el dolor, pero estamos considerando dárselos. Responda cada pregunta con la mayor sinceridad posible. No hay respuestas correctas ni incorrectas.

	<b>Nunca</b>	<b>Rara vez</b>	<b>A veces</b>	<b>A menudo</b>	<b>Muy a menudo</b>
	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
1. ¿Con qué frecuencia le cambia el estado de ánimo?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. ¿Con qué frecuencia ha sentido necesidad de tomar dosis mayores de medicamento para tratar el dolor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. ¿Con qué frecuencia se ha sentido impaciente con sus médicos?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. ¿Con qué frecuencia se ha sentido tan presionado por distintas cosas que no puede manejarlas?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. ¿Con qué frecuencia hay tensión en su casa?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. ¿Con qué frecuencia ha contado sus pastillas para el dolor para ver cuántas le quedan?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. ¿Con qué frecuencia se ha sentido preocupado de que la gente lo juzgue por tomar medicamentos para el dolor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. ¿Con qué frecuencia se siente aburrido?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. ¿Con qué frecuencia ha tomado más medicamentos para el dolor de los que debía tomar?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. ¿Con qué frecuencia le ha preocupado que lo dejen solo?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. ¿Con qué frecuencia ha sentido ansias de tomar medicación?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	<b>Nunca</b>	<b>Rara vez</b>	<b>A veces</b>	<b>A menudo</b>	<b>Muy a menudo</b>
	0	1	2	3	4
12. ¿Con qué frecuencia otras personas se han mostrado preocupadas por el uso que usted hace de la medicación?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. ¿Con qué frecuencia alguno de sus amigos cercanos ha tenido problemas de alcoholismo o drogadicción?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. ¿Con qué frecuencia otras personas le dijeron que tenía mal genio?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. ¿Con qué frecuencia se ha sentido dominado por la necesidad de conseguir medicamentos para el dolor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. ¿Con qué frecuencia se ha quedado sin medicamentos para el dolor antes de tiempo?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. ¿Con qué frecuencia otras personas le han impedido conseguir lo que usted merece?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. ¿Con qué frecuencia, en su vida, ha tenido problemas legales o ha sido arrestado?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. ¿Con qué frecuencia ha asistido a reuniones de alcohólicos anónimos o narcóticos anónimos?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. ¿Con qué frecuencia ha tenido una discusión tan fuera de control que alguien resultó herido?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. ¿Con qué frecuencia ha sido abusado sexualmente?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. ¿Con qué frecuencia otras personas han sugerido que tiene un problema de drogadicción o alcoholismo?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. ¿Con qué frecuencia ha tenido que pedir prestados medicamentos para el dolor a sus familiares o amigos?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>