Physical Medicine & Pain Management Associates P.C.

William Tham, MD
Susan Zimmerman, MD
Thomas, Lee, MD

Sophia Leonard-Burns, PA-C
Michael T. Weeks, PA-C
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Amy Raquepau, PA-C

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Physical Medicine and Pain Management will use your health related information for the purposes of providing you with medical treatment, obtaining payment for services rendered and/or for general health care operations. Your health related information will be submitted through the following mechanisms: US Postal Service, fax submissions, Internet submissions for insurance inquiries (protected by Firewall), voice mail and/or personal communications.

The most common entries that will receive this information are: other providers, facilities, insurance companies and pharmacies. More specific information pertaining to our practice policies is provided for you in our "Notice of Privacy Practices" statement. You have a right to review this statement prior to receiving health care and prior to signing this consent. The terms of our Notice of Privacy Practices may change, at any time. You may contact the office and request a revised policy. Also, if you so choose, you may request that we restrict the use or your health information for the purpose of treatment, payment and/or health care operations. We are not required to agree with your requested restrictions. In the event we do agree with your requested restrictions, we will adhere to these restrictions. If we do not agree with your request, we will discontinue treatment.

I have been provided a copy of the practice's Notice of Privacy Practices. **Patients Initials**__________________

I understand that I may revoke, at any time, this consent. This revocation will not effect previous actions, prior to revocation. **Patients Initials**__________________

DESIGNATION OF PERSONAL REPRESENTATIVE

I____authorize my health care provider and/or medical staff to discuss my medical records, medical procedures, receive test results (i.e. blood work, MRI, x-rays, surgery, etc) schedule appointments, cancel appointments, discuss health insurance information and/or accounting questions, call for refill on my medications or to pick up any medication the doctor prescribes for me with the designated persons listed below.

Designated persons that may receive my information:____

____

If you want to limit your disclosure of health information, please list the limitations:_____________________________________

____

Patient Name (Print):____ Date___________________

Patient (or Patient's Representative) Signature:____

Witness Signature: ____

Precision Diagnostics • Personalized Care • Pain Relief Solutions

Annapolis Office
2002 Medical Parkway, Ste 430
Annapolis, MD 21401
(o) 410-266-2700
(f) 410-268-1862

Glen Burnie Office
331 Oak Manor Drive, Ste 102
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(o) 410-761-0030
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MEDICATION/NARCOTIC MANAGEMENT AGREEMENT

This Agreement between__________________________________ ("Patient") and Physical Medicine and Pain Management Associates ("Doctor") is for the purpose of establishing an **agreement/understanding** between Doctor and Patient on clear conditions for the prescribing and use of pain controlling medications prescribed by the Doctor for the Patient.

Doctor and Patient **agree/concur** that this Agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship.
The Patient agrees to and accepts the following conditions for the use of pain medications prescribed by the providers of this practice.

- I understand that a reduction in the intensity of my pain and an improvement in my ability to do activities of daily living are the goals of this program.
- I realize that it is my responsibility to keep myself and others from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will refrain from the activity until I have clearance from a provider of this practice.
- Pain medications are to be prescribed only by a **single physician**. I will not attempt to get pain medication from any other health care provider while I am under the care of the practice. If the pain trial is successful, this practice will transfer prescription writing to my primary doctor for long-term follow-up.
- No lost or stolen prescriptions or medications will be replaced. I am responsible for my own medications, and it is my responsibility to verify that prescriptions are filled correctly and that the medication supply will last until my next scheduled follow-up visit.
- No increase in medication doses will be made without the approval of this practice. No prescriptions will be refilled early due to independent increases in medication. These independent increases in medication dosage will not be tolerated.
- I understand that pain medications will not be refilled over the phone. Medications can be refilled only during normal business hours.
- All patients are expected to comply fully with their individual treatment recommendations. Failure to keep any of Patient's scheduled appointments or follow the above agreements will be interpreted as an act of noncompliance, and may result in discharge from the care of this practice.
- It is understood that emergencies do arise and under special circumstances, exceptions may be made to these policies.
- Periodic pill counts and Urine Drug Screens may be required at the discretion of the provider. I understand that failure to comply with these requests may result in a medication violation or discharge from the practice.
- Pain medications are to be filled at a **single pharmacy**. I will not attempt to fill prescriptions at multiple pharmacies, in the event that my pharmacy is unable to fill my prescriptions I will notify the office immediately for verification and approval to fill at another pharmacy.
- I understand that use of illicit substances can result in immediate discharge from the practice.

CAUTION: Opioid medications may cause drowsiness. Patients should abstain from alcohol use with opioid and benzodiazepine medications. Use care when operating a car or dangerous machinery. Federal law prohibits the alteration of a prescription or transfer of these drugs to any person other than the patient for whom they were prescribed.

I, the undersigned, attest that the above guidelines have been explained to me, and that all of my questions and concerns regarding treatment have been adequately addressed. I agree to comply with the above guidelines. I have received a copy of this document. **Please note, should a violation of this policy occur it may result in your discharge from the practice**

Patient's Signature:____ Date:_______________

Witness Signature: ____ Date:_______________

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AUTHORIZATION TO RECEIVE BENEFITS & FINANCIAL AGREEMENT

PATIENT NAME ____ **DATE OF BIRTH** ________________

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN: I hereby authorize payment by (insurance company) _________________________________ be paid directly to Physical Medicine & Pain Management Associates, P.C. (PMPMA) for services rendered.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I hereby authorize the release of medical information required by my insurance carrier or its designated review agent, or if applicable my employer's workers compensation insurance carrier in order to determine benefits to which I may be entitled, or to designated agents of Physical Medicine & Pain Management Associates, P.C. a copy of this authorization will be deemed as valid as the original authorization.

FINANCIAL AGREEMENT: I hereby assume financial responsibility for and agree to make payment in full to Physical Medicine & Pain Management Associates, P.C. for any/or all charges for services or medical supplies received by me and/or any of my dependents not otherwise authorized or paid by my insurance carrier. Payment is to be made within 30 days as statements are presented with settlement in full, or payment arrangements to be made with the Business Office.

I certify that the financial information given is true, accurate and complete to the best of my knowledge, and further authorize PMPMA to investigate any and all financial information given concerning this or related claims. I further understand and agree that PMPMA reserves the right to charge interest on, collect reasonable attorney's fees for collection of, and/or report delinquent accounts to Equifax Credit Information Services, Inc.

This entire authorization and agreement are valid for all episodes of care rendered by any and all physicians and/or physician assignments associated with PMPMA. I permit a copy of this authorization and agreement to be used in place of the original.

Patient's Signature:____ Date:__________________

Witness Signature: ____ Date:__________________

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