DENVER
# PAIN RELIEF CENTER

## Patient Information

Patient Name:_____ DOB_____

Mailing Address:_____
City_____ St:_____ Zip_____

Phone:_____ Primary ☐HOME ☐CELL ☐WORK
_____ Secondary ☐HOME ☐CELL ☐WORK

SSN:_____ Gender: Male / Female

Marital Status: Single / Divorced / Married / Widowed
Race:_____ Ethinicity: Hispanic or Latino / not Hispanic or Latino

## Worker's Comp

Employer: _____ Case #: _____
Date of Injury:_____
Case Manager Name:_____ Case Manager Phone:_____

Case Manager Fax:_____

## Emergency Contact

Emergency Contact Name:_____ Emergency Contact Name_____
Phone:_____ Phone:_____
Relationship:_____ Relationship:_____

## Insurance Information

Primary Insurance:_____ Policy #_____
Subscriber: SELF SPOUSE PARENT OTHER
Subscriber's Name:_____ SSN:_____

Secondary Insurance:_____ Policy #_____
Subscriber: SELF SPOUSE PARENT OTHER
Subscriber's Name:_____ SSN:_____

## Pharmacy

Pharmacy Name:_____ Location:_____ Phone:_____

## Referral Information

Referring Physician:_____

799 E Hampden Ave Ste 315
Englewood, CO 80113
Phone: 303-789-5242 Fax: 303-789-5264
www.denverprc.com

DENVER PAINRELIEF Center

Name: _____

Date of Birth: _____

Have you been to any previous pain management (circle one)? Yes No

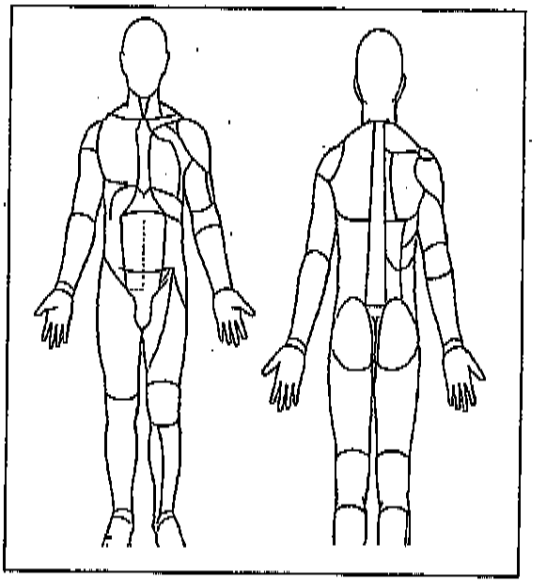
If yes, name of physician(s): _____

Work Status: ____ Regular Duty _____ Light Duty (Restrictions): _____

_____ Off Work (date last worked): _____ _____ Retired (year retired): _____

Disabled (since): _____ If disabled, by what doctor: _____

*In the diagram to the right, please shade the areas of your pain:*



Reason for Visit (Location of Pain): _____

Onset of pain (when did pain begin): _____

Severity of Pain (on a scale of 0-10, with 10 being the most painful): _____

Pain Scale: From 0 - 10 what is your pain level today? _____
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain)

What is your range of pain in the past month? _____
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain)

Duration of pain (how long does it last): _____

What aggravates your pain: _____

What relieves your pain: _____

*Medications you are presently taking (Include all over the counter and prescribed medications):*

| Medication Name | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |

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**Name:**_____ **Height:**_____ **Weight:**_____

**Please check the boxes that pertain to you:**

**Constitutional:**
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss

**HEENT:**
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Eye Discharge
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Nasal Drainage
- ☐ Sinus Pressure
- ☐ Sore Throat
- ☐ Visual Changes

**Respiratory:**
- ☐ Chronic Cough
- ☐ Cough
- ☐ Known TB Exposure
- ☐ Shortness of Breath
- ☐ Wheezing

**Cardiovascular:**
- ☐ Chest Pain
- ☐ Claudication
- ☐ Edema
- ☐ Palpitations

**Gastrointestinal:**
- ☐ Abdominal Pain
- ☐ Blood in Stools
- ☐ Change in Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of Appetite
- ☐ Nausea
- ☐ Vomiting

**Genitourinary:**
- ☐ Dribbling
- ☐ Dysuria
- ☐ Hematuria
- ☐ Polyuria
- ☐ Slow Stream
- ☐ Urinary Frequency
- ☐ Urinary Incontinence
- ☐ Urinary Retention

**Reproductive:**
- ☐ Erectile Dysfunction
- ☐ Penile Discharge
- ☐ Sexual Dysfunction

- ☐ Abnormal Pap Smear
- ☐ Dysmenorrhea
- ☐ Dyspareunia
- ☐ Hot Flashes
- ☐ Irregular Menses
- ☐ Vaginal Discharge

**Metabolic/Endocrine:**
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Polydipsia
- ☐ Polyphagia

**Neurological:**
- ☐ Dizziness
- ☐ Extremity Numbness
- ☐ Extremity Weakness
- ☐ Gait Disturbance
- ☐ Headache
- ☐ Memory Loss
- ☐ Seisures
- ☐ Tremors

**Psychiatric:**
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

**Integumentary:**
- ☐ Brittle Hair
- ☐ Brittle Nails
- ☐ Hair Loss
- ☐ Hirsutism
- ☐ Hives
- ☐ Pruritus
- ☐ Mole Changes
- ☐ Rash
- ☐ Skin Lesion

**Musculoskeletal:**
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Weakness
- ☐ Neck Pain

**Lymphatic:**
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Lymphadenopathy

**Immunologic:**
- ☐ Contact Allergy
- ☐ Environmental Allergy
- ☐ Food Allergy
- ☐ Seasonal Allergy

Any New Medications?

_____

_____

_____

_____

Any New Allergies?

_____

_____

_____

DENVER PAINRELIEF Center

Name: _____

Date of Birth: _____

**Past Medical History:**

- ☐ Anemia
- ☐ Angina
- ☐ Arrhythmia
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Blood clots
- ☐ Brain tumor
- ☐ Cerebrovascular accident
- ☐ Cirrhosis
- ☐ Colon cancer
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Kidney failure
- ☐ Liver disease
- ☐ Lung cancer
- ☐ Migraine headaches
- ☐ Multiple Sclerosis
- ☐ Parkinson's disease
- ☐ Peripheral nerve disorder
- ☐ Renal disease
- ☐ Rheumatoid arthritis
- ☐ Seizure disorder
- ☐ Spinal cord tumor
- ☐ Thyroid disease
- ☐ Tremor

**Gender Specific:**

- ☐ Breast cancer

**Past Surgical History:**

- ☐ Anesthesia reaction
- ☐ Aneurysm clipping/resection
- ☐ Angioplasty with stent
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arthroscopy knee
- ☐ Arthrodesis
- ☐ Back surgery
- ☐ CABG
- ☐ Carotid endarterectomy
- ☐ Carpal tunnel release
- ☐ Cataract extraction
- ☐ Cerebral shunt
- ☐ Cholecystectomy
- ☐ Colectomy
- ☐ Colostomy
- ☐ Discectomy
- ☐ Gastric bypass
- ☐ Hernia repair
- ☐ Hip replacement
- ☐ Knee replacement
- ☐ Laminectomy
- ☐ LASIK
- ☐ Muscle biopsy
- ☐ ORIF
- ☐ Pacemaker
- ☐ Small bowel resection
- ☐ Spinal infusion pump
- ☐ Thyroidectomy
- ☐ Tonsillectomy

**Gender Specific:**

- ☐ Cesarean section
- ☐ D and C
- ☐ Hysterectomy
- ☐ Mastectomy
- ☐ Myomectomy
- ☐ Reduction mammoplasty
- ☐ TAH / BSO
- ☐ Vaginal hysterectomy

***Other Past Medical and/or Surgical History:***

| System: | Disease: | Year: | Management: | Year: | Outcome: |
|---|---|---|---|---|---|
| | | | | | |
| System: | Disease: | Year: | Management: | Year: | Outcome: |
| | | | | | |
| System: | Disease: | Year: | Management: | Year: | Outcome: |
| | | | | | |
| System: | Disease: | Year: | Management: | Year: | Outcome: |
| | | | | | |

Spinal Cord Stimulator (if yes, when): Trial: Y / N Year: _____ Permanent Implant: Y / N Year: _____

Morphine Pump (if yes, when): Trial: Y / N Year: _____ Permanent Implant: Y/N Year: _____

***Family History:***

| Relation | Status | Diagnosis (cause of death y/n?) | Relation | Status | Diagnosis (cause of death |
|---|---|---|---|---|---|
| Mother | Alive & Well/Deceased | | Sister | Alive & Well/Deceased | |
| Father | Alive & Well/Deceased | | Brother | Alive & Well/Deceased | |

***Patient History:***

Tobacco usage: current ____ former ____ never ____ type _____ units/day _____ years used _____

Alcohol usage: no ____ yes ____ formerly ____ Caffeine usage: no ____ yes ____

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DENVER
PAIN RELIEF CENTER

# Authorization to Disclose

I, _____ authorize the following list of people (family/ friends) to have access to my medical information. This information includes, but is not limited to: picking up prescriptions, scheduling/ cancelling appointments, or receiving information regarding my treatment, etc. at Colorado Springs Pain Relief Center.

1) Name:_____ Phone:_____

2) Name:_____ Phone:_____

3) Name:_____ Phone:_____

4) Name:_____ Phone:_____

I understand that only the people listed on this form will be given medical information and I can add, remove, or change this list at any time.

_____ _____

Signature of Patient Date

DENVER
PAIN RELIEF CENTER

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

PRINT PATIENT'S FULL NAME _____ D.O.B _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____

At the request of the individual, I _____, do hereby authorize release of:

___All medical records ___Pathology Reports ___ ER Reports
___History & Physical ___Lab Reports _X_Other
___Progress Notes _X_Radiology Reports **LAST 3 DR NOTES**
___Operative Notes

___I Do ___I Do Not authorize release of information related to AIDS or HIV infections, psychiatric care and/ or psychological assessment, for alcohol and/or drug abuse.

RELEASE INFORMATION **FROM:** _____
DOCTOR/FACILITY NAME & ADDRESS

_____
PHONE/ FAX NUMBER

RELEASE INFORMATION **TO:** **DENVER PAIN RELIEF CENTER-DR SINGLETON**
DOCTOR/FACILITY NAME & ADDRESS

**719-598-8155/719-694-0102**
PHONE/ FAX NUMBER

PURPOSE OF DISCLOSURE:
___ Referral to Specialist ___ Insurance ___ Worker's Comp ___ Change of Doctor
___ Legal Investigation ___ Disability ___Personal ___ Other_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior o notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of Individual or Personal Representative Date

NOTE: HealthPort has been contracted to provide the service of processing medical records requests. Currently, the charge is $14.00 (0-10 pgs), $0.50 per page (11-40 pgs), $0.33 per page (41+ pgs). Prices are subject to change without notice. For further information on pricing, please contact HealthPort at 1-800-367-1500

DENVER PAIN RELIEF CENTER

Name:_____
Date of Birth:_____

## CONSENT FOR CHRONIC OPIOID THERAPY

***DENVER Pain Relief Center physicians and allied health professional are prescribing Opioid medicine, sometimes called narcotic analgesics, to me for pain management. This decision was made because my condition is serious or other treatments have not helped my pain.***

**Please initial each of the following statements below.**

_____ I am aware that the use of such medicine has certain risks associated with it, including but not limited to, sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.

_____ I am aware about the possible risks and benefits of other types of treatments that do not involve the use of Opioids. I will tell my physician about all other medicines and treatments that I am receiving. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: Using heavy equipment or motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for his/herself.

_____ I am aware that certain other medicines such as nalbuphine (Bubain), pentazocaine (Talwin), buprenorphine (Buprenex), and butorphanol (Stadol), may reverse the action of the medicine I am using for pain control. Taking any of these medications while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other physician that I am taking an Opioid as my pain medicine and cannot take any of the medicines listed above.

_____ I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug, and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has family or personal history of addiction. I agree to tell my physician my complete and honest personal drug history and that of my family to the best of my knowledge.

_____ I understand that physical dependence is a normal, expected results of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that Opioid withdrawal is uncomfortable but not life threatening.

_____ I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help, and may cause unacceptable side effects. Tolerance or failure to respond well to Opioids may cause my physician to choose another form of treatment.

_____ **MALES ONLY:** I am aware that chronic Opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my physician or family physician may check my blood to see if my testosterone level is normal.

_____ **FEMALES ONLY:** If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric physician and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent on Opioids. I am aware that the use of Opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an Opioid.

**Please initial each of the following statements below.**

_____1. The patient must provide copies of reports from previous and concurrent treating physicians.

_____2. The patient must provide CPRC accurate patient address and phone number and keep us up to date of any changes in their personal information.

_____3. DENVER Pain Relief Center physicians and allied health professionals will be the only providers to prescribe controlled substances for pain.

_____4. The patient must provide us with the name and phone number of the pharmacy that the patient is using and keep us up to date with any changes.

_____5. The patient must be seen for regular office visits to receive a medication refill. Prescriptions will be written for a 30-day supply and will not be filled earlier than one (1) month.

_____6. The safety of the patient's medication is the patient's responsibility. Lost or stolen medications will not be replaced.

_____7. The patient is responsible for all prescriptions/medications given and must understand that if the prescriptions/medications are lost, misplaced or destroyed they **cannot be replaced.**

_____8. **No refills will be made after hours, on weekends, or on holidays.** The patient will need to notify the office for a refill at least three (3) days in advance.

_____9. Other classifications of medications may be prescribed to assist in pain management and limit opiate use.

_____10. Other therapies may be ordered to assist in pain management such as nerve blocks, TENS, physical or occupational therapy, and/or psychological counseling as appropriate to the diagnosis.

_____11. The patient understands that no trustworthy patient-doctor relationship can be had with a patient that abuses illegal drugs. "Street Drugs" such as marijuana, cocaine, amphetamines, etc. are in and out of themselves dangerous. Mixed with some of the medicines often used in pain management, the combination could be lethal.

_____12. We will periodically check the patient's urine for compliance with therapy. The urine will be tested for the presence of the prescribed drugs as well as several other drugs, including illegal drugs.

_____13. The patient understands that if we find a urine sample that contains illegal substances, we may end the patient-doctor relationship.

_____14. Alcohol is a very dangerous drug when ingested in combination with prescription opiates. No alcohol should ever be consumed while taking prescribed opiates while under the care of DENVER Pain Relief Center. The patient also should fully understand that if alcohol metabolites are found in the patient's urine during routine drug testing, DENVER Pain Relief Center may terminate the doctor-patient relationship.

_____15. The patient has the right to refuse such random or periodic urine testing. DENVER Pain Relief Center reserves the right to end the patient-doctor relationship on a patient that refused to comply with our urine drug testing policy.

The patient authorizes any physician office, hospital or clinic to provide full details of medical history and treatment to CPRC for the use of continuity or care by completing a medical release form up to date. Any breach of these guidelines may results in the patient being discharged from the practice.

I have read this form or have had this form 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 medications.

_____ _____

Patient Signature Date

_____ _____

Witness printed name & Signature Date

DENVER
PAIN RELIEF CENTER

Name:_____

DOB:_____

**CONSENT FOR CARE & TREATMENT**

I, _____do hereby agree and give my consent for DPRC to furnish medical care and treatment to myself considered necessary and proper in diagnosing or treating my physical and mental condition.

PATIENT/ RESPONSIBLE PARTY_____ DATE_____

*PLEASE NOTE: IF YOU HAVE 3 NO SHOWED APPOINTMENTS IN A 12 MONTH PERIOD IT IS GROUNDS FOR TERMINATION FROM THE PRACTICE**

**BENEFIT ASSIGNMENT/ RELEASE OF INFORMATION**

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to DENVER PAIN RELIEF CENTER. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment. INFORMATION PRIVACY: CPRC will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, and have copies available for distribution. The undersigned acknowledges receipt of this information.

PATIENT/ RESPONSIBLE PARTY_____ DATE_____

**FINANCIAL POLICY STATEMENT**

We will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made due to policy termination, you will be responsible for the amount of money refunded to your insurance company. We reserve the right to assess a finance charge of 18% annually for balances carried over an extended period of time. Benefits and eligibility are verified prior to your visit as a courtesy and as a results, we are not responsible for incorrect information provided by your insurance company as it relates to co-pay or benefit plan limitations. Your policy must be in effect at the time of service and subject to individual plan limitations and exclusions as mandated by your plan. An authorization is not a guarantee of payment. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to DPRC. By signing below, I hereby authorize DENVER PAIN RELIEF CENTER and the physicians, staff, and hospitals associated with DENVER PAIN RELIEF CENTER to release medical and other information acquired in the course of my examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies, third party payers, and/or other physicians or healthcare entities required to participate in my care. I understand that I must check one of more the following types of health information to indicate that I authorize that information type to be released to the necessary insurance companies, third party payers, and/or other physicians and/or healthcare entities required to participate in my care. By checking one or more of the following boxes, the health information I authorize to be released may include any of the following:

- ☐ DIAGNOSIS, EVALUATION, AND/ OR TREATMENT FOR ALCOHOL AND/ OR DRUG ABUSE.
- ☐ RECORDS OF HTLV-III OR HIV TESTING(AIDS TEST) RESULT, DIANGOSIS, AND/OR TREATMENT.
- ☐ PSYCHIATRIC AND/OR PSYCHOLOGICAL RECORDS, OR EVALUATION AND/OR TREATMENT FOR MENTAL, PHYSICAL, AND/OR EMOTIONAL ILLNESS, INCLUDING NARRATIVE SUMMARY, TESTS, SOCIAL WORK ASSESSMENT, MEDICATION, PSYCHIATRIC EXAMINATION, PROGESS NOTES, CONSULTATIONS, TREATMENT, PLAN, AND/OR EVALUATIONS.

DENVER
PAIN RELIEF CENTER

Name:_____

DOB:_____

By my signature below, I hereby authorize assignment of financial benefits directly to DENVER PAIN RELIEF CENTER and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges NOT covered by this assignment. I authorize DENVER PAIN RELIEF CENTER personnel to communication by mail, answering machine message, and/or email according to the information I have provided in my patient registration information.

*The above may not apply for those patients that are considered WORKER'S COMPENSATION; however, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services.*

***I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.**

PATIENT/RESPONSIBLE PARTY_____ DATE_____

# ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the attached Privacy Notice.

_____ _____

Patient or Personal Representative Signature

Date

_____

Patient Name

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

# SOAPP®-R

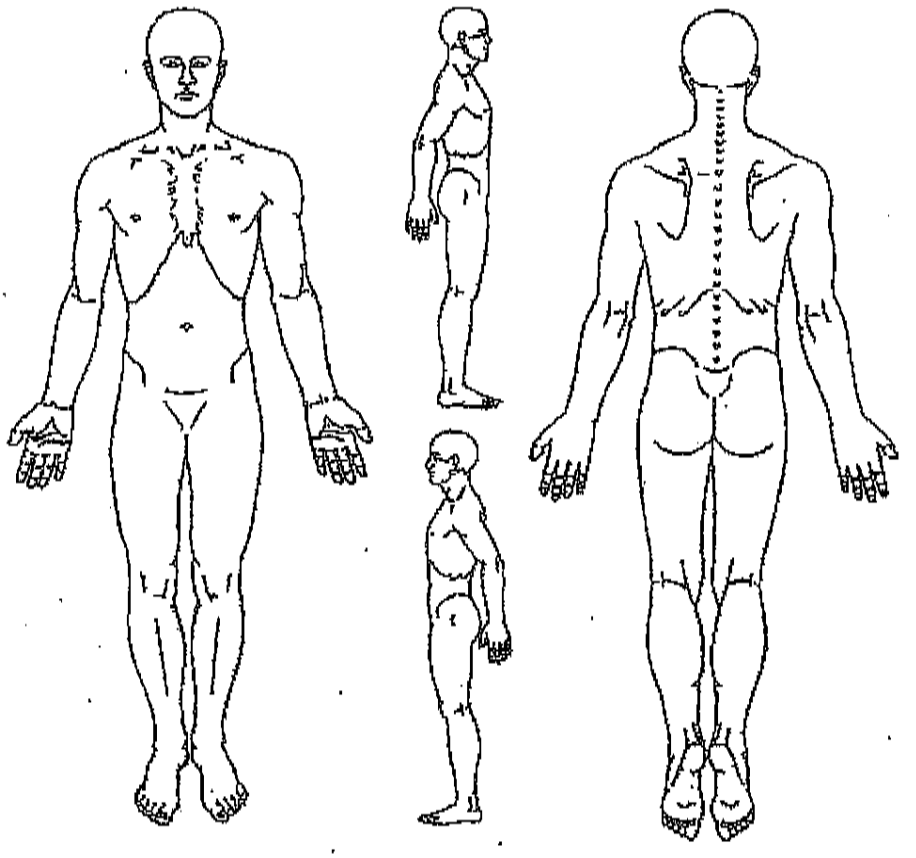
The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

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

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

Name:_____ Date:_____

**Please mark where your pain is located:**



R L L R

**Current Pain Level:**

_____/10

**How many months/ years ago did the main area of pain start?**_____

**Describe your pain:**

- o Aching
- o Burning
- o Discomfort
- o Dull
- o Gnawing
- o Numbness
- o Piercing
- o Sharp
- o Shooting
- o Stabbing
- o Throbbing
- o Tingling
- o Other_____

**What makes your pain worse:**

- o Nothing
- o Stairs
- o Changing Position
- o Daily Activities
- o Jumping
- o Lifting
- o Lying Down/ Rest
- o Rolling over in bed
- o Sitting
- o Standing
- o Walking
- o Weather
- o Other:_____

**What makes your pain better:**

- o Nothing
- o Heat
- o Ice
- o Injections
- o Lying down/ rest
- o Massages
- o Movement
- o Anti-inflammatory Meds
- o Pain Meds/ drugs
- o Physical therapy
- o Exercise/ stretching
- o Other:_____

# HEALTH ASSESSMENT QUESTIONNAIRE (HAQ-DI)©

Name: _____ Date: _____

**Please place an "x" in the box which best describes your abilities OVER THE PAST WEEK:**

| | WITHOUT ANY DIFFICULTY | WITH SOME DIFFICULTY | WITH MUCH DIFFICULTY | UNABLE TO DO |
|---|---|---|---|---|
| **DRESSING & GROOMING** | | | | |
| **Are you able to:** | | | | |
| Dress yourself, including shoelaces and buttons? | ☐ | ☐ | ☐ | ☐ |
| Shampoo your hair? | ☐ | ☐ | ☐ | ☐ |
| **ARISING** | | | | |
| **Are you able to:** | | | | |
| Stand up from a straight chair? | ☐ | ☐ | ☐ | ☐ |
| Get in and out of bed? | ☐ | ☐ | ☐ | ☐ |
| **EATING** | | | | |
| **Are you able to:** | | | | |
| Cut your own meat? | ☐ | ☐ | ☐ | ☐ |
| Lift a full cup or glass to your mouth? | ☐ | ☐ | ☐ | ☐ |
| Open a new milk carton? | ☐ | ☐ | ☐ | ☐ |
| **WALKING** | | | | |
| **Are you able to:** | | | | |
| Walk outdoors on flat ground? | ☐ | ☐ | ☐ | ☐ |
| Climb up five steps? | ☐ | ☐ | ☐ | ☐ |

**Please check any AIDS OR DEVICES that you usually use for any of the above activities:**

- ☐ Devices used for Dressing (button hook, zipper pull, etc.)
- ☐ Built up or special utensils
- ☐ Crutches
- ☐ Cane
- ☐ Wheelchair
- ☐ Special or built up chair
- ☐ Walker

**Please check any categories for which you usually need HELP FROM ANOTHER PERSON:**

☐ Dressing and grooming ☐ Arising ☐ Eating ☐ Walking

PLEASE TURN PAGE OVER AND COMPLETE

Please place an "x" in the box which best describes your abilities OVER THE PAST WEEK:

| | WITHOUT ANY DIFFICULTY | WITH SOME DIFFICULTY | WITH MUCH DIFFICULTY | UNABLE TO DO |
|---|---|---|---|---|
| **HYGIENE** | | | | |
| Are you able to: | | | | |
| Wash and dry your body? | ☐ | ☐ | ☐ | ☐ |
| Take a tub bath? | ☐ | ☐ | ☐ | ☐ |
| Get on and off the toilet? | ☐ | ☐ | ☐ | ☐ |
| **REACH** | | | | |
| Are you able to: | | | | |
| Reach and get down a 5 pound object (such as a bag of sugar) from above your head? | ☐ | ☐ | ☐ | ☐ |
| Bend down to pick up clothing from the floor? | ☐ | ☐ | ☐ | ☐ |
| **GRIP** | | | | |
| Are you able to: | | | | |
| Open car doors? | ☐ | ☐ | ☐ | ☐ |
| Open previously opened jars? | ☐ | ☐ | ☐ | ☐ |
| Turn faucets on and off? | ☐ | ☐ | ☐ | ☐ |
| **ACTIVITIES** | | | | |
| Are you able to: | | | | |
| Run errands and shop? | ☐ | ☐ | ☐ | ☐ |
| Get in and out of a car? | ☐ | ☐ | ☐ | ☐ |
| Do chores such as vacuuming or yard work? | ☐ | ☐ | ☐ | ☐ |

Please check any AIDS OR DEVICES that you usually use for any of the above activities:

☐ Raised toilet seat ☐ Bathtub bar ☐ Long-handled appliances for reach

☐ Bathtub seat ☐ Long-handled appliances in bathroom ☐ Jar opener (for jars previously opened)

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

☐ Hygiene ☐ Reach ☐ Gripping and opening things ☐ Errands and chores

Your ACTIVITIES: To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

| COMPLETELY | MOSTLY | MODERATELY | A LITTLE | NOT AT ALL |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Your PAIN: How much pain have you had IN THE PAST WEEK?
On a scale of 0 to 100 (where zero represents "no pain" and 100 represents "severe pain"), please record the number below.

☐☐☐

Your HEALTH: Please rate how well you are doing on a scale of 0 to 100 (0 represents "very well" and 100 represents "very poor" health), please record the number below.

☐☐☐

# PRIVACY NOTICE

**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.**

For purposes of this notice, the terms "Surgery Partners Affiliated Covered Entity" and/or "DENVER PAIN RELIEF CENTER," and the pronouns "we," "us" and "our" refer to those entities under common ownership or control with Surgery Center Holdings, Inc. that have been designated from time to time as a single affiliated covered entity for HIPAA Privacy Rule purposes. Denver Pain Relief Center includes the entity providing you with this Privacy Notice.

**This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.**

## I. Uses and Disclosures of Protected Health Information

Denver Pain Relief Center may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the Denver Pain Relief Center has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

A. Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription or to a laboratory to order a blood test. We may also disclose protected health information to physicians who may be treating you or consulting with Denver Pain Relief Center with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. Payment. Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurance company to get approval for the procedure that we have scheduled. For example, we may need to disclose information to your health insurance company to get prior approval for the surgery. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide to you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. This may include disclosure of demographic information to anesthesia care providers for payment of their services.

C. Operations. We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of all or a portion of Denver Pain Relief Center and to provide quality care to all patients. Health care operations include such activities as: quality assessment

and improvement activities, employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities.

In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. Other Uses and Disclosures. As part of treatment, payment and health care operations, we may also use or disclose your protected health information for the following purposes:

1. To remind you of your surgery date.
2. We may, from time to time, contact you to provide information about treatment alternatives or other health-related benefits and services that we provide and that may be of interest to you.

**II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object**

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. When Legally Required or Permitted. We will disclose your protected health information when we are required or permitted to do so by any federal, state or local law. One situation in which we may disclose your protected health information is in the instance of a breach involving your protected health information, to notify you, law enforcement and regulatory authorities, as necessary, of the situation, and others as appropriate to resolve the situation.

B. When There Are Risks to Public Health. We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

C. To Report Suspected Abuse, Neglect Or Domestic Violence. We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

D. To Conduct Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. In Connection With Judicial And Administrative Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. For Law Enforcement Purposes. We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries.
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if Denver Pain Relief Center has a suspicion that your health condition was the result of criminal conduct.
- In an emergency to report a crime.

G. To Coroners, Funeral Directors, and for Organ Donation. We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Once you have been dead for 50 years (or such other period as specified by law), we may use and disclose your health information without regard to the restrictions set forth in this notice. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

H. For Research Purposes. We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information. Under certain circumstances, your information may also be disclosed without your authorization to researchers preparing to conduct a research project or for research on decedents or to researchers pursuant to a written data use agreement.

I. In the Event of a Serious Threat to Health or Safety. We may, consistent with applicable law and ethical standards of conduct; use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

J. For Specified Government Functions. In certain circumstances, federal regulations authorize Denver Pain Relief Center to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

K. For Worker's Compensation. Denver Pain Relief Center may release your health information to comply with worker's compensation laws or similar programs.

L. Business Associates. We may contract with one or more business associates through the course of our operations. We may disclose your health information to our business associates so that they can perform the job we have asked them to do. We required that our business associates sign a business associate agreement and agree to safeguard the privacy and security of your health information.

## III. Uses and Disclosures Permitted without Authorization but with Opportunity to Object

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your surgery or payment related to your surgery. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures which you Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization. Examples of disclosures that require your authorization are:

A. Marketing. Except as otherwise permitted by law, we will not use or disclose your health information for marketing purposes without your written authorization. However, in order to better serve you, we may communicate with you about refill reminders and alternative products. Should you inquire about a particular product-specific good or service, we may also provide you with informational materials. We may also, at times, send you informational materials about a particular product or service that may be helpful for your treatment.

B. No Sale of Your Health Information. We will not sell your health information to a third party without your prior written authorization.

V. Your Rights

You have the following rights regarding your health information:

A. The right to inspect and copy your protected health information. You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your surgeon and Denver Pain Relief Center use for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last page of this Privacy Notice. If you request a copy of your

information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

Please contact our Privacy Officer if you have questions about access to your medical record.

B. **The right to request a restriction on uses and disclosures of your protected health information.** You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

If you request that Denver Pain Relief Center not disclose your protected health information to your health plan for the purposes of payment or healthcare operations (but not treatment), and if you are paying for your treatment out of pocket in full, then Denver Pain Relief Center must honor your requested restriction. Otherwise, Denver Pain Relief Center is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If Denver Pain Relief Center does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

C. **The right to request to receive confidential communications from us by alternative means or at an alternative location.** You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

D. **The right to request amendments to your protected health information.** You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.

E. **The right to receive an accounting.** You have the right to request an accounting of certain disclosures of your protected health information made by Denver Pain Relief Center. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a DENVER PAIN RELIEF CENTER directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. After January 1, 2014 (or a later date as permitted by HIPAA), the list of disclosures will include disclosures made for treatment, payment or health care operations using our electronic health record (if we have one for you). We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. **The right to obtain a paper copy of this notice.** Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

## VI. Our Duties

Denver Pain Relief Center is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this

Notice and to make the new Notice provisions effective for all future protected health information that we maintain. If Denver Pain Relief Center changes its Notice, we will provide a copy of the revised Notice by sending a copy of the revised Notice via regular mail or through in-person contact at your next visit. In the event there has been a breach of your unsecured protected health information, we will notify you.

## VII. Complaints

You have the right to express complaints to Denver Pain Relief Center and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to Denver Pain Relief Center by contacting Denver Pain Relief Center's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

## VIII. Contact Person

Denver Pain Relief Center's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by Denver Pain Relief Center you may submit a complaint to our Privacy Officer by sending it to:

Privacy Officer
c/o Surgery Center Holdings, Inc.
333 W. Wacker Drive, Suite 1010
Chicago, Illinois 60606

The Privacy Officer can be contacted by telephone at 888.668.2633.

## IX. Effective Date

This Notice is effective April 14, 2003, with revisions effective February 17, 2010 and September 23, 2013.