Comprehensive Pain Care, P.C.

Donald Taylor, M.D.
Wendy Gray, M.D.

Date: _____ Status: (circle one) Minor Single Married Widow(er) Divorced Separated

Patient Name: _____ SS# _____

Address: _____

Date of Birth: _____ ☐ Male ☐ Female Home Phone: _____

Employer name/address: _____

Work Phone: _____ Cell / pager _____

Spouse: _____ SS# _____ Birthdate _____

Employer name/address: _____

Family Physician: _____ Referring _____

Primary Insurance, name / address: _____

ID and Group# _____ Relation to patient _____

Secondary Insurance: _____

ID and Group# _____ Relation to patient _____

Please list three (3) people that we could contact in the event of an emergency:

1. _____ Ph# _____ Relationship: _____

2. _____ Ph# _____ Relationship: _____

3. _____ Ph# _____ Relationship: _____

Pharmacy: _____

I understand that I am responsible for checking with my insurance regarding any pre-certification and referral requirements.

Authorization for Release of Information
And Payment of Benefits

Comprehensive Pain Care, P.C.

770-421-8080 • Fax: 770-421-9566

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities.

I hereby assign and authorize payment to the above state office of all medical and/or surgical benefits, including major medical benefits, to which I am entitled to under any insurance policy or policies, under self-insurance program, or any other benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to the above stated office by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Print patient name and date of birth: _____

_____ _____

Signature of person providing the authorization | Date

_____ _____

Relationship to patient if not patient | Reason patient unable to sign

PROTECTING YOUR HEALTH INFORMATION

What you need to know about the Health Insurance Portability and Accountability Act

Identify theft. Credit card fraud. Computer viruses. Concern for the privacy and security of personal information has never been greater. Our concern for the safety and security of your personal healthcare information has never been taken more seriously.

While we have always gone to great lengths to ensure the privacy of your personal health information, we will soon be getting additional help from the Federal government in the form of new regulations. These regulations will help standardize privacy and security requirements across the country and across all different type of healthcare organizations.

New Regulations Passed-
These regulations are part of the Healthcare Insurance Portability and Accountability Act, HIPAA for short. HIPAA does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange electronic healthcare data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage, although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individual health information and medical recor s.

HIPAA Ensures the Privacy and Security of Individual Health Information-
Currently, individual state laws govern the use and disclosure of this information, creating many inconsistencies and gaps in the way you health information is protected. HIPAA sets minimum security and privacy standards for healthcare organizations to follow. If a state has more stringent privacy and security laws, then those would be followed instead. In addition, HIPAA sets heavy penalties for violations of these standards and the misuse of personal health information.

Defining Individual Health Information-
Every time you go to see a doctor, or admitted to the hospital, fill a prescription or send a claim to an insurance company, a record is made of your confidential health information. This type of information is referred to as individually identifiable health information and is the type of information regulated by HIPAA. It can be in any formation-electronic, paper or oral.

Healthcare organizations that collect and manage this type of information and are therefore covered by these regulations including physicians, physical therapists, mental health professionals, dentists, chiropractors, optometrists, podiatrists, and others; hospitals, health plans, employers, healthcare clearinghouses such as claims processors; and other healthcare organizations who conduct administrative and financial transactions.

Added Control over Health Information-
Under HIPAA, you have new rights to understand and control how you health information is used:

- **Right to Education-Healthcare providers and health plans are required to provide you with a clear written explanation of how they intend to use and disclose your information.**
- **Right to Access Medical Records-You have the right to see and get copies of your medical records, request changes and receive a history of non-routine disclosures of your personal health information.**
- **Right of Consent-Healthcare providers are required to obtain prior consent before sharing personal health information for purposes other than treatment, payment and healthcare operations.**
- **Right to Rec urse-You have the right to file a formal complaint if you believe that violations of the regulations were made.**

In general, HIPAA tries to find a balance between protecting your privacy and allowing the appropriate flow of information between healthcare providers that is necessary for you to access care and receive quality healthcare services.

The following websites may also contain helpful information on HIPAA:

American Medical Association-http://www.ama-assn.org/
American Dental Association-http://www.ada.org/
American Chiropractic Association-http://www.amerchiro.org/
American Optometric Association-http://www.aoanet.org/
American Podiatric Medical Association-http://www.apma.org/
American Academy of Opthalmology-http://www.aao.org/

Comprehensive Pain Care, P.C.
840 Church Street, Suite D, Marietta, GA 30060
P: 770-421-8080 F: 770-421-9566

Date: _____

I have been given the HIPAA Pamphlet regarding the protection of my medical records.

At the time of my original visit at this office, I received the patient handbook.

I understand that if I should have any questions regarding my medical records, the protection thereof and /or any issues of concern, I may speak to the office manager.

Patient Name: _____
(Please Print)

Signature: _____

Date: _____

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Protecting Your Medicines At Home

Today, the abuse of prescription medicines is more widespread than the abuse of traditional street drugs, excluding marijuana. In fact, the number of people who abuse prescription medicines is approximately three times the number of people who abuse cocaine[1]. Thus we all need to be vigilant in protecting our own medicines from abuse.

The most commonly abused medicines are opioid pain relievers, sedatives, and stimulants. Abusers obtain these drugs by fraud and by theft. Fraud includes *forging prescriptions* and *faking illnesses* in order to trick doctors into writing prescriptions. Thieves not only burglarize pharmacies, they also steal from individual patients, such as yourself.

Sometimes this person is a family member or caregiver-someone you would never suspect. Here are some steps you can take to:

Protecting Your Medicines

- **Do not share your medicines with anyone.**
- **Lock medicines and medical supplies, such as syringes, in a locking cabinet and secure the key.**
- **Always store medicines in a cool, dry place protected from light.**
- **Do not store prescriptions drugs in the bathroom medicine cabinet. A bathroom is hot and Humid; bathroom medicine cabinets are rarely locked.**
- **Do not store medicines in the glove compartment of your car or in the kitchen cabinets. Here, too, heat and moisture degrade medicines and may make them unsafe.**
- **Keep medicines out of direct sunlight and away from a radiator or heating duct.**
- **Make sure all bottles are tightly closed.**
- **Do not store medicines inside purses, coat pockets, nightstands, or other locations easily accessed by others.**
- **Store all medicines in their original containers with the original labels intact.**
- **Do not store medicines in the refrigerator or freezer unless directed by your pharmacist.**

Protecting Yourself

- **Never take medicine in the dark. Always turn the light on and wear your glasses if Required for reading.**
- **Read the label each time to check the dosage before opening the bottle.**
- **Examine the medicine itself before taking it. Check for capsules or tablets that differ from the others in the bottle.**
- **If the appearance or the odor of the medicine has changed, check with your pharmacist**

before taking it.

- Follow the directions carefully. Special instructions, such as " Do not take with grapefruit" or " Take two hours before or after meals, " are given because they affect how the medicine works or how it affects your body.
- Never use medicines after they have expired. Expiration dates are listed with EXP and a date. If only a month and year are listed, the medicine can be used until the last day of that month; that is , "EXP 9/2019" means the medicine can be taken until the last day of September 2019.
- Inspect your medicine storage cabinet at least once a year. Ask yourself these questions:

Do I need the medicine?
Is it in its original container with the label firmly attached?
Is there an expiration date on the label?
Are my doctors and my pharmacist aware of all the medicines I am taking?

Protecting Your Loved Ones

Each year accidental poisonings from medicines and household chemicals kill about 30 children and prompt more than 1 million calls to the nation's Poison Control Centers. The number to reach your Poison Control Center is **1-800-222-1222.**

- Avoid taking medicines in front of children. Children like to imitate grown-ups.
- Use child-resistant packaging on your medicines whenever possible-it saves lives.
- Replace child-resistant caps securely after each use.
- Never call medicine " candy," call it " medicine."
- Do not discard any medicines, including patches, in the wastebasket where children can find them.
- If you are giving medicine to a loved one, check the label every time you give it.
- Keep track of doses to ensure that you are correctly following the directions on the bottle label.

*If you ever suspect that anyone has stolen your prescription medicine, report it to your local police department. You may save the thief from tragedy... you may even save a life.

[1]Substance Abuse & Mental Health Services Administration, 2008 National Survey on Drug Use and Health.
Information in this document was obtained from Educational Services by Purdue Pharma L.P, Stanfod, CT 06901-3431

Comprehensive Pain Care, PC
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I, _____, have read and understand my
(Print Name)
responsibilities as listed in the "Protecting Your Medicines at Home" document.

_____ _____
Signature Date

Comprehensive Pain Care, PC
840 Church Street, Suite D Marietta, Georgia 30060

FINANCIAL POLICY:

We are committed to meeting your healthcare needs at Comprehensive Pain Care, PC. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines.

1. Payment is expected at the time of service.

2. We will file your insurance for you if we are a participating provider of your plan. However, you will be responsible for any and all services in excess of your insurance limits as well as all non-covered services.

3. All co-payments and deductibles are due at the time of service.

4. If we are not participating providers of your plan, full payment is due at the time of service, unless prior arrangements have been made. At your request we will give you complete forms that will be accepted by your insurance company for reimbursement.

We will mail you a monthly billing statement for any outstanding balances. If arrangements need to be made you must contact the billing manager prior to your next appointment.

I acknowledge that I understand and accept this financial policy.

_____ _____

Signature Date

Comprehensive Pain Care, P.C.

840 Church Street, Suite D
Marietta, Georgia 30060
Tel: 770-421-8080
Fax: 770-421-9566

Date _____

I _____ give permission for Dr. Donald Taylor, Dr. Wendy Gray and staff to speak with the following:

_____

_____

_____

Regarding any information pertaining to my medical treatment.

Patient Name: _____
(please print)

Patient Signature: _____

Comprehensive Pain Care, P.C.
Office Based Opioid Addiction Treatment
840 Church Street, Suite D
Marietta, Georgia 30060
770-421-8080

Patient Treatment Agreement

Patient Name:_____
Date:_____

As a participant in buprenorphine treatment for opioid misuse and dependence, I *freely* and *voluntarily* agree to accept this treatment agreement as follows:

I agree to keep and be on time to all my scheduled appointments.

I agree to adhere to the payment policy outlined by this office.

I agree to conduct myself in a courteous manner in the doctor's office.

I agree not to sell, share or give any of my medication to another person.

I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.

I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.

I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine is filled, that the behavior will be reported to the office and could result in my treatment being terminated without recourse for appeal.

I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may results in my not being able to get my medication/prescription until the next scheduled visit.

I agree to keep my medication in a safe place, away from children, friends or pets. I understand that the accidental ingestion of medications by anyone else could be fatal. (It is ***highly*** recommended that all medications be kept in a locked safe or similarly secure storage area.)

I agree that lost medication will not be replaced regardless of why it was lost.

I agree to be honest and notify the office of all medications I am taking.

I agree not to obtain medications from other doctors, pharmacies, or other sources without telling the physicians at Comprehensive Pain Care.

I understand that mixing buprenorphine with other medications, especially benzodiazepines (for example, Valium, Klonopin, or Xanax) can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses).

I agree to take my medication as the doctor has instructed and not to alter the way I take my medication without consulting him first.

I understand that the physician will not be held responsible if I do not follow directions and misuse or fail to take my medication as prescribed.

I am aware that rare cases of hepatitis, sometimes fatal, have been reported with the use of buprenorphine and I accept this risk.

I understand that medication alone is not sufficient treatment for my condition. Therefore, I agree to participate in one-on-one counseling with a therapist approved by the physician at Comprehensive Pain Care, I agree to enroll in the "Here to Help" Program (This is a Free Program) and agree to engage in the Suboxone Group Therapy Program.

I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (except nicotine).

I agree to provide random urine samples for alcohol/drug testing at the doctor's request.

I understand that violations to any of the above may be grounds for termination of treatment at this facility.

_____ _____

Patient Signature Date

_____ _____

Witness Date

Donald R. Taylor, M.D.
Office Based Opioid Addiction Treatment
840 Church St.
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PATIENT INTAKE: SOCIAL/FAMILY HISTORY

(To be completed by patient)

Patient Name _____

(Circle one) Married Single Long-term relationship Divorced/Separated

Years married/ in long-term relationship _____Times Married _____Times Divorced _____

Children? ( ) N ( ) Y Current ages (list) _____

Residing with you? ( ) N ( ) Y If no, where? _____

Where are you currently living? _____

Do you have family nearby? ( ) N (Please describe) _____

Education (check most recent degree):

( ) Graduate school ( ) College ( ) Professional or Vocational School

( ) High School Grade _____

Are you currently employed? ( ) N Where (if "no," where were you last employed?) _____

What type of work do/did you do? _____ How long have/did you work (ed) there? _____

Have you ever been arrested or convicted? ( ) N

( ) DWI ( ) Drug-related ( ) Domestic violence ( ) Other

Have you ever been abused? ( ) N

( ) Physically ( ) Sexually (including rape or attempted rape) ( ) Verbally ( ) Emotionally

Have you ever attended:

AA ( ) Current ( ) Past **NA** ( ) Current ( ) Past **CA** ( ) Current ( ) Past

ACOA ( ) Current ( ) Past **OA** ( ) Current ( ) Past

If you are not currently attending meetings, what factors led you to stop? _____

Have you ever been in counseling or therapy? ( ) N (Please describe) _____

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PATIENT INTAKE: MEDICAL HISTORY

(To be completed by patient)

Use the opposite side of the page as necessary to complete your answers. **Please print legibly.**

Name _____

Address _____

Phone (w) _____ (h) _____ (c) _____

DOB _____ Age _____ SS# _____

Emergency Contact _____

Relationship to patient _____ Phone _____

Primary care physician _____ Phone _____

Date of last physical _____ Have you ever had an EKG? ( ) N Date _____

Current or past medical conditions (check all that apply)

( ) Asthma/respiratory
( ) Cardiovascular (heart attack, high cholesterol, angina)
( ) Hypertension
( ) Epilepsy or seizure disorder
( ) GI disease
( ) Head trauma
( ) HIV/AIDS
( ) Diabetes
( ) Liver problems
( ) Pancreatic problems
( ) Thyroid disease
( ) STDs
( ) Abnormal Pap smear
( ) Nutritional deficiency

Other (Please describe) _____

_____

_____

If there a family history of any of the illnesses listed above, **please put an "F" next to that illness**

MD NOTES _____

_____

_____

Patient: _____ Date: _____

Is there a family history of anything NOT listed here? (Please explain) _____

_____

_____

MD NOTES _____

_____

Have you ever had **surgery** or been **hospitalized**? (Please describe) _____

_____

_____

MD NOTES _____

_____

Childhood Illnesses

Measles ( ) N ( ) Y Mumps ( ) N ( ) Y Chicken Pox ( ) N ( ) Y

Have you or a family member ever been diagnosed with a **psychiatric** or **mental illness**? (Please describe)

_____

Have you ever taken or been prescribed **antidepressants**? ( ) N For what reason _____

Medication(s) and dates of use _____ Why stopped _____

Please list all current **prescription medications** and how often you take them (example: Dilantin 3x/day).

DO NOT include medications you may be currently misusing (that information is needed later) _____

_____

_____

Please list all current **herbal medicines**, **vitamin supplements**, etc. and how often you take them

_____

MD NOTES _____

_____

_____

Please list any **allergies** you have (penicillin, bees, peanuts)

_____

MD NOTES _____

Patient: _____ Date: _____

Tobacco History

Cigarettes: Now? ( ) N ( ) Y In the past? ( ) N ( ) Y

How many per day on average? _____ For how many years? _____

Pipe: Now? ( ) N ( ) Y In the past? ( ) N ( ) Y

How often per day on average? _____ For how many years? _____

Have you ever been **treated for substance misuse**? ( ) N (Please describe when, where and for how long)

_____

How long have you been **using substances?** _____

Substance Use History

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							
Ecstasy							
Other							

Patient: _____ Date: _____

Did you ever stop using any of the above because of dependence? ( ) N (Please list) _____

What was your longest period of abstinence? _____

MD NOTES _____

Donald R. Taylor, M.D.
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TELEPHONE APPOINTMENT REMINDER CONSENT

I _____ give Donald R. Taylor, M.D and members of his/her
Patient Name (Print)

staff working at the location indicated above my permission to call me prior to an appointment to remind me of the appointment date and time.

I would prefer to be called at (check all that apply):

- □ Home _____
- □ Work _____
- □ Cell _____

Yes, this office may leave (check all that apply):

- □ Voice mail at my Home
- □ Voice mail at my Work
- □ Voice mail on my Cell
- □ Messages with people at my Home
- □ Messages with people at my Work

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

_____ _____
Patient Signature Date

_____ _____ _____
Parent/Guardian Signature Parent/Guardian Name (Print) Date

_____ _____ _____
Witness Signature Witness Name (Print) Date

Donald R. Taylor, M.D.
Office Based Opioid Addiction Treatment
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Marietta, Georgia 30060
770-421-8080

APPOINTED PHARMACY CONSENT

SUBOXONE® C (buprenorphine HCl/naloxone HCl dihydrate) sublingual tablet
SUBUTEX® C (buprenorphine HCl) sublingual tablet

I _____ do hereby: **(MD check all that apply)**
Patient Name (Print)

☐ Authorize _____ at the above address to disclose my treatment for opioid
Physician Name (Print)
dependence to employees of the pharmacy specified below. Treatment disclosure most often includes, but may not be limited to, discussing my medications with the pharmacist, and faxing/calling in my buprenorphine prescriptions directly to the pharmacy.

☐ Agree to purchase all SUBOXONE, SUBUTEX, and any other medications related to my treatment from the pharmacy specified below.

☐ Agree not to use any pharmacy other than the one specified below for the duration of my treatment with the physician specified above, unless specific arrangements have been made with the physician.

☐ Agree to make payment arrangements with the pharmacy specified below *in advance* of treatment, so that my buprenorphine prescriptions can be filled and either delivered to the office addressed given above or picked-up by employees of the same.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____ _____
Patient Signature Date

_____ _____ _____
Parent/Guardian Signature Parent/Guardian Name (Print) Date

_____ _____ _____
Witness Signature Witness Name (Print) Date

Appointed Pharmacy: Name_____ Phone_____

Address_____

Donald R. Taylor, M.D.
Office Based Opioid Addiction Treatment
840 Church St.
Suite Þ
Marietta, Georgia 30060
770-421-8080

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I _____ authorize _____ at the above address to:
Patient Name (Print) Physician Name (Print)

MD check all that apply

☐ Receive my medical history information from the following physicians:
(name, address)_____

(name, address)_____

☐ Receive my treatment records from the following therapist
Therapist (name, address)_____

☐ Release my treatment information/records to the following healthcare professional
(name, address)_____

☐ Release my treatment information to the health insurance company listed below for billing purposes
Insurance Provider (name, address) _____

_____

This information is for the following purposes (any other use is prohibited): _____

_____

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

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_____ _____
Patient Signature Date

_____ _____ _____
Parent/Guardian Signature Parent/Guardian Name (Print) Date

_____ _____ _____
Witness Signature Witness Name (Print) Date