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 records.

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

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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.

PATIENT INFORMATION

Name _____ Date _____/_____/_____

Date of Birth _____/____/_____ Age_____ Sex _____

To be filled out by the nurse:

BP:_____/_____ P:_____R:_____T:_____ Weight:_____ Height:_____

General Health Review:
(By answering the following questions, you will help your physician better understand and treat your pain.)

Medical History (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, as well as psychiatric illnesses, etc.)

_____ _____ _____
_____ _____ _____

Surgical History (**unrelated** to pain; such as appendectomy)

_____ _____ _____
_____ _____ _____

Surgical History (**related** to pain; such as laminectomy, include nerve blocks, epidurals and other injections here)

_____ _____ _____
_____ _____ _____

Allergies (include medication and food allergies)

_____ _____ _____
_____ _____ _____

Medication Intolerances (include side effects from previous medications, such as gastritis, nausea, constipation, etc.)

_____ _____ _____
_____ _____ _____

Current Physicians (include name and phone number and/or office address):

Primary Care Physician:_____

(We do not provide primary care services and highly recommend that you have a primary care physician.)

Psychiatrist:_____

Clinical Psychologist and/or counsler:_____

Specialty physician:_____

Specialty physician:_____

Do you have any of the following? (Circle all that apply):

Headaches	Stomach Pain	Chest Pain
Vision Problems	Nausea	Shortness of Breath
Hearing Problems	Vomiting	Urinary Problems
Dizziness	Constipation	Rashes
Difficulty Swallowing	Diarrhea	Swollen Joints
		Chronic Fatigue

Domestic Situation:

Circle one: Single Married Widowed Divorced

Children: No Yes Ages:_____

With whom do you live? _____

Are there any substance abuse issues in the household? Yes_____ No_____

If yes, please explain _____

Are you able to take care of yourself? Yes_____ No_____

If not, please enter name of caregiver_____

Work History:

Job Years worked Why did you leave?

_____

_____

Legal Matters:

Are you presently involved in a lawsuit? Yes_____ No_____ If yes, please explain.

_____

_____

Substance Use:

Which of the following drugs or substances, if any, have you used in the past? (Circle all that apply)
Next to each drug or substance that you've circled, indicate if you used it occasionally ("O"), frequently ("F"), or continuously ("C").

Alcohol_____	Barbiturates _____	Cocaine_____
Heroin_____	Amphetamines _____	Marijuana_____
Other_____	Other_____	Other_____
(specify)	(specify)	(specify)

Are you presently using any of the drugs or substances below? (Circle all that apply)
Next to each drug or substance that you've circled, indicate if you use it occasionally ("O"), frequently ("F"), or continuously ("C").

Alcohol_____	Barbiturates _____	Cocaine_____
Heroin_____	Amphetamines _____	Marijuana_____
Other_____	Other_____	Other_____
(specify)	(specify)	(specify)

Have you felt the need to cut down on your medication use? (Circle one.) Yes No

Have people annoyed you by criticizing your medication use? (Circle one.) Yes No

Do you presently smoke cigarettes or use tobacco in any form? (Circle one.) Yes No

If not, did you ever smoke cigarettes or use tobacco in any form? (Circle one.) Yes No

How many packs do (did) you smoke a day? _____ For how many years? _____

PAIN ASSESSMENT

When and how did your pain problem start? _____

_____

_____

As far as you know, what is the cause of your pain (ie, the diagnosis)? _____

_____

_____

What tests and studies have been done?

(for example: MRI, CT-Scan, X-Rays)	Month/Year Done	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What doctors have you seen for this problem in the past? (Do not list current physicians listed above). When did you see them? What did they do? (for example: Doctor did physical exam, ordered tests, prescribed medication)

Doctor's Name	Month/Year Seen	What Was Done

Circle the words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable
Intermittent	Continuous	

Rate your pain on the scales below using a 0 to 10 scale where 0 = no pain and 10 = the worst pain that you can possibly imagine.

Circle the number that best describes your pain at its **worst during the last month**.

0	1	2	3	4	5	6	7	8	9	10

Circle the number that best describes your pain at its **least during the last month**.

0	1	2	3	4	5	6	7	8	9	10

Circle the number that best describes your pain **on average during the last month**.

0	1	2	3	4	5	6	7	8	9	10

Circle the number that best describes your pain as it is **right now**.

0	1	2	3	4	5	6	7	8	9	10

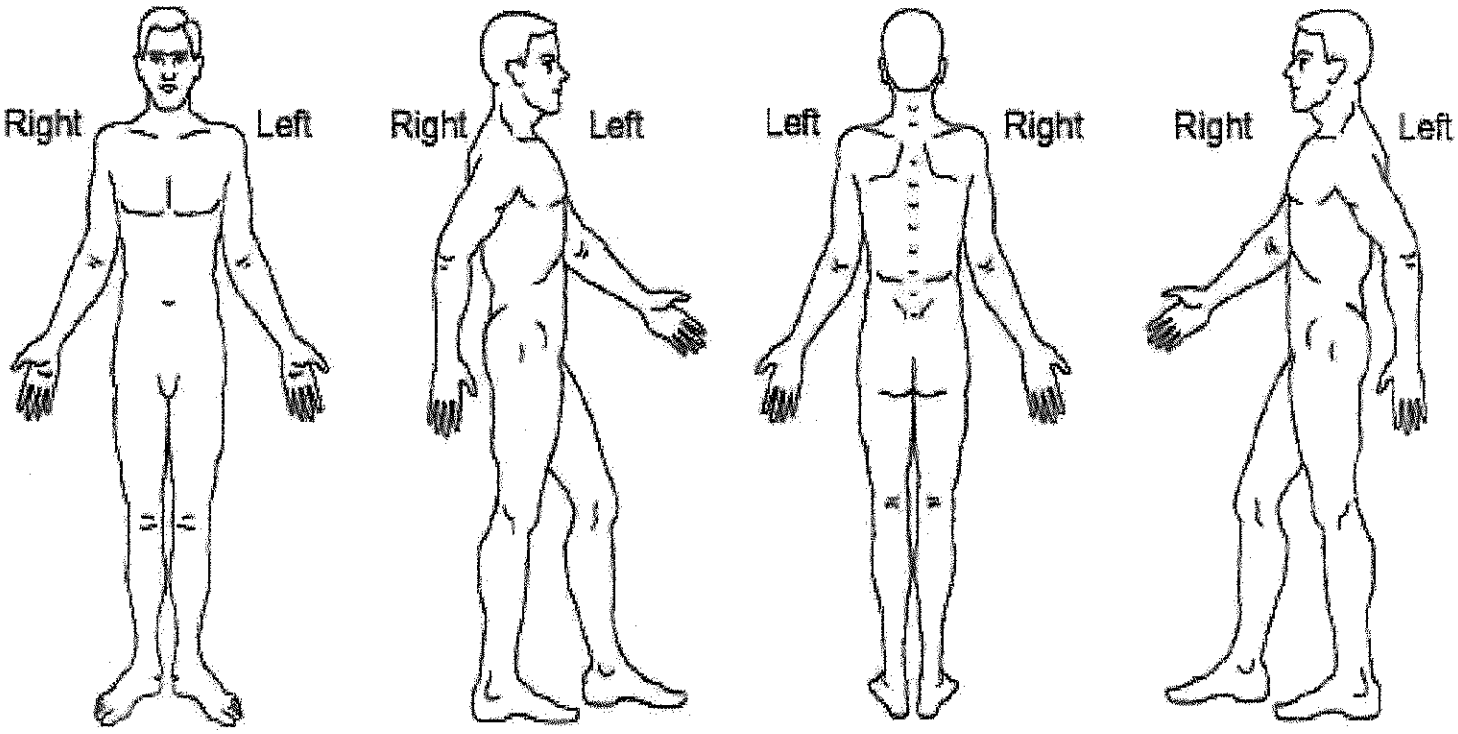
What sorts of things make this pain feel **better** (for example: heat, rest, medicine)?

What sorts of things make this pain feel **worse** (for example: walking, standing, lifting)?

The following statement best reflects th .ffect of my **current pain medications** (ci. ; one):

1. My pain medication does not help at all.
2. My pain medication provides some relief but not enough to be considered meaningful.
3. My pain medication helps and definitely improves my quality of life.

On the diagram below, shade the area(s) where you feel pain. "X" the areas that hurt the most. Please be as exact as possible.



Circle the numbers below that best describe how pain has interfered with your daily functioning.

General Activity

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

Mood

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

Walking Ability

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

Normal Work Routine

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

Relations With Other People

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

Sleep

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

Enjoyment of Life

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

Ability to Concentrate

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

Appetite

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

What level of pain do you think you could function with on a daily basis?

0	1	2	3	4	5	6	7	8	9	10

No Pain — Worst pain imaginable

ORT Form

*Mark each box that applies.

1. Family History of Substance Abuse:

Alcohol	☐
Illegal Drugs	☐
Prescription Drugs	☐

2. Personal History of Substance Abuse:

Alcohol	☐
Illegal Drugs	☐
Prescription Drugs	☐

3. Age (mark box if between 16-45) ☐

4. History of Preadolescent Sexual Abuse ☐

5. Psychological Disease

Attention Deficit Disorder, Bipolar, Depression	☐
Obsessive-Compulsive Disorder, Schizophrenia	☐

Name_____ Date_____

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.* No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

Comprehensive Pain Care, P.C.

Donald R. Taylor, M.D.
840 Church Street, Suite D Marietta, Georgia 30060
Office: 770-421-8080 Fax: 770-421-9566
drtaylor@cpcnopain.com

Name _____

Date _____

Place an X in one box that best describes your answer to each question.

Question:	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total:	

Fatigue Severity Scale (FSS)

The Fatigue Severity Scale (FSS) is a method of evaluating the impact of fatigue on you. The FSS is a short questionnaire that requires you to rate your level of fatigue.

The FSS questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

- A low value (e.g., 1) indicates strong disagreement with the statement, whereas a high value (e.g., 7) indicates strong agreement.
- It is important that you circle a number (1 to 7) for every question.

FSS Questionnaire

During the past week, I have found that:	**Disagree ← → Agree**						
1. My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
2. Exercise brings on my fatigue.	1	2	3	4	5	6	7
3. I am easily fatigued.	1	2	3	4	5	6	7
4. Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
5. Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
6. My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
7. Fatigue interferes with carrying out certain duties and responsibilities.	1	2	3	4	5	6	7
8. Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
9. Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7
						Total Score:	

Scoring your results

Now that you have completed the questionnaire, it is time to score your results and evaluate your level of fatigue. It's simple: Add all the numbers you circled to get your total score.

The Fatigue Severity Scale key

A total score of less than 36 suggests that you may not be suffering from fatigue.

A total score of 36 or more suggests that you may need further evaluation by a physician.

Your next steps

This scale should not be used to make your own diagnosis.

If your score is 36 or more, please share this information with your physician. Be sure to describe all your symptoms as clearly as possible to aid in your diagnosis and treatment.

Epworth Sleepiness Scale (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high chance that you would doze or fall asleep in that situation.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:
0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing
It is important that you circle a number (0 to 3) on each of the questions.

Situation	Chance of dozing (0-3)				
Sitting and reading	0	1	2	3	
Watching television	0	1	2	3	
Sitting inactive in a public place—for example, a theater or meeting	0	1	2	3	
As a passenger in a car for an hour without a break	0	1	2	3	
Lying down to rest in the afternoon	0	1	2	3	
Sitting and talking to someone	0	1	2	3	
Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3	
In a car, while stopped in traffic	0	1	2	3	
				Total Score:	

Scoring your results

Now that you have completed the questionnaire, it is time to score your results and evaluate your own level of daytime sleepiness. It's simple. Just add up the numbers you put in each box to get your total score.

The Epworth Sleepiness Scale key

A total score of less than 10 suggests that you may not be suffering from excessive daytime sleepiness.

A total score of 10 or more suggests that you may need further evaluation by a physician to determine the cause of your excessive daytime sleepiness and whether you have an underlying sleep disorder.

Your next steps

This scale should not be used to make your own diagnosis. It is intended as a tool to help you identify your own level of daytime sleepiness, which is a symptom of many sleep disorders.

If your score is 10 or more, please share this information with your physician. Be sure to describe all your symptoms, as clearly as possible, to aid in your diagnosis and treatment.

It is important to remember that true excessive daytime sleepiness is almost always caused by an underlying medical condition that can be easily diagnosed and effectively treated.

Principles of Medical Practice

At Comprehensive Pain Care, P.C. we are dedicated to providing the best medical care possible. We feel that the practice of pain medicine (algology) requires unique characteristics of the physicians, nurses, psychologists, counselors and other caregivers that choose to devote themselves to this difficult area of healthcare. We all feel strongly that our patients deserve the best possible care. To that end, our physicians have developed a set of principles to guide our practice. We feel that it is our duty to adopt such guidelines to protect our patients from the many harmful influences that can impede their care in today's healthcare environment. The following standards define what we consider to be the essentials of honorable business conduct for physicians and other healthcare practitioners. Our physicians follow these principles and expect all employees of the Practice for Pain Medicine to adopt similar standards. (Parts of this set of standards were adopted from the American Medical Association's "Principle of Medical Ethics".)

1. A physician must be dedicated to providing competent medical series with compassion and respect for human dignity.

2. A physician shall openly tell the patient about appropriate treatment options, answer questions about medical risks and give the patient the current and accurate medical facts needed to make informed decisions about treatment.

3. A physician shall provide patients with information about other physicians and medical resources when this will benefit the patients.

4. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficit in character or competence, or who engage in fraud or deception.

5. A physician shall practice within all confines of the law; but shall also recognize a responsibility to seek changes in those laws that are contrary to the best interest of their patients.

6. A physician shall respect the rights of patients, colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

7. A physician shall respect the rights of patients, staff and colleagues to have an office environment free from sexual or racially motivated harassment. Any sexually oriented activity between the staff and patients is unethical and will not be tolerated.

8. A physician shall care for patients without regard to sex, race, creed, color, sexual orientation or previous condition of servitude.

9. A physician shall continue to study; continually learn how to apply advanced scientific knowledge to the care of their patients.

10. A physician shall, except in cases of emergency, be free to choose to whom they deliver medical services.

11. A physician shall recognize their responsibility to participate in activities contributing to an improved community.

12. A physician shall recognize their own responsibility to their own and to their families' physical, mental and spiritual health.

13. A physician shall at times, for personal renewal and/or professional education, need to be away from his practice. During this time, the physician will arrange for appropriate coverage for his patients.

If you think that our physicians or staff is not adhering to these principles, if there is any concern that you have not been treated with compassion, dignity and respect, or if you feel in any way harassed or subjected to unethical treatment, please report your concerns to our practice manager immediately.

Date: _____

Signature: _____