PAIN MEDICINE ASSOCIATES, P.A.
LYNN R. FASSY, M.D.

Pain Management

3945 Clark Road
Sarasota, FL 34233
Phone: (941) 923-2500
Fax: (941) 923-2520

Dear Valued Patient,

How a Team Approach Helps Reduce Pain

Pain is a very complex reality which affects every part of your body, not just where your pain is centered. When you experience pain, every system in your body responds, your heart beats faster, blood pressure goes up, you breathe faster, you are unable to think clearly, you become tense, even your digestion is affected!

Most of us can understand why different specialties are needed to treat and manage our pain. Medication, injections, physical and neuromuscular therapy are also necessary in order to understand and manage our pain.
Did you know that how you think or deal about your condition can actually make your pain worse?

Research has shown that when your body is in pain, all the other systems in the body also react, the way you interpret it greatly influences your bodies' ability to deal with the pain. Your brain's response to pain is to tense, called "muscular bracing" and your immune systems stop producing white blood cells, which makes you more susceptible to infection and disease. Your brain also stops making serotonin which can make you become discouraged and depressed. Behavioral therapy uses proven methods which teach your brain to relax, immediately reducing the pain and giving you more control over your condition.

Long term narcotic medication use causes physical and psychological dependence. Taking medication also can never make the pain go away, and physical or neuromuscular therapy may only help for a while. You must learn a new way to deal with your pain. Behavioral therapy will help you enjoy a better quality of life, as well as perhaps reduce your pain.

Your willingness to cooperate, to attend all appointments and to be open to a variety of techniques and therapies will be the most important factor in your ability to cope with your pain.

Our physicians, behavioral therapist and neuromuscular therapist will work together as a team to reduce or even eliminate your pain.

We look forward to working together with you to improve your pain.

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Lifetime Authorization for Release of Medical Information, Consents and Assignment of Benefits

Medicare: I authorized any holder of medical or other information about me to release to the Social Security Administration, HCFA, any intermediaries or carriers any information needed for this and all subsequent Medicare claims for services furnished to me. I also request that payment of authorized Medicare benefits be made on my behalf to Pain Medicine Associates, P.A. A copy of this authorization may be used in place of the original.

Signed_____ Date: _____

Medigap: I request that payment of authorized Medigap benefits be made on my behalf to Pain Medicine Associates.

Signed: _____ Date:_____

Signature of File/Assignment of Benefits: I authorize Pain Medicine Associates, P.A. or his billing agent to file and Medicare, Medigap, third party insurance carrier claims and authorize payment of benefits to be made on my behalf directly to Pain Medicine Associates, P.A. I also agree to endorse and turn over any payments made to me directly for services rendered.

Signed_____ Date: _____

Consent to Treat: I willingly consent to treatment by Pain Medicine Associates, and agree to hold harmless Pain Medicine Associates, P.A. and anyone/entity associated with Pain Medicine Associates from all liability except for gross negligence n connection with my treatment rendered by them.

Signed_____ Date: _____

Financial Policy: I fully understand that I am responsible for all charges incurred through Pain Medicine Associates, P.A regardless of my insurance coverage. I also understand that there is an 1 ½ % finance charge to all outstanding balances. I also understand that if other services are required to effect satisfactory settlement, I will be responsible for all costs.

I also understand that Pain Medicine Associates attempts to call and remind patients of their upcoming appointments as a courtesy, and do authorize them to leave a message on my answering device.

Signed: _____ Date: _____

I declare I am signing as an authorized representative for the patient requesting treatment who is unable to sign on his/her behalf.

Signed: _____ Printed Name: _____

Date: _____

Reason for patient's inability to sign: _____

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MEDICATION AGREEMENT

The purpose of this agreement is to give you information about the medications you may be taking for pain management and to assure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of pain medication therapy might be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using pain medications to treat pain. I am aware that failure to abide by any of the following conditions will be considered a breach of agreement, and at the sole discretion of my physician, may result in the termination of our physician-patient relationship.

1. I am responsible for my pain medications. I agree to take the medication only as prescribed and to contact my physician's office before making any changes. I understand that increasing my dose without the close supervision of my physician could lead to drug overdose, causing severe sedation, respiratory depression, or death. I understand that decreasing or stopping my medication without the close supervision of my physician could lead to withdrawal.

2. **You should use one** physician to prescribe and monitor all opioid medications and adjunctive analgesics. I will not request or accept controlled substance medications from any other physician or individual if I am receiving medication from Dr. Fassy or Pain Medicine Associates.

3. You should use **one** pharmacy to obtain all opioid prescriptions and adjunctive analgesics prescribed by your physician.
   Pharmacy: _____ Phone number: _____

   I understand there are side effects with pain medication therapy. Most common are nausea and vomiting, skin rash, constipation, and drowsiness. Less common side effects are mental slowing, flushing, sweating, itching, urinary difficulties and jerkiness. Overuse of pain medications can cause decreased respiration (breathing). It is my responsibility to notify my physician's office of any side effects that may occur. I am also responsible for notifying my pain physician immediately if I need to visit another physician or emergency room due to pain or if I become pregnant.

4. I understand that the pain medication is strictly for my own use. The pain medication should never be given to others. You may not give or sell your medications to any other person under any circumstances. If you do, you may endanger that person's health. It is also against the law. Any evidence of drug hoarding, acquisition of any pain medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.

5. You should not use any illicit substances, such as cocaine, heroin, etc. while taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship. The use of alcohol and opioid medications is contraindicated.

Initials: _____

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6. You will communicate fully to your physician to the best of your ability at the initial and all follow-up visits your pain level and functional activity with any side effects of the medications. This information allows your physician to adjust your treatment plan accordingly.

7. I understand that I must contact my pain physician before taking Benzodiazepines (drugs like Valium or Ativan), sedatives (drugs like Soma, Xanax or Fiorinal) and antihistamines (drugs like Benadryl). I understand that the combination use of the above drugs and pain medication, as well as alcohol and pain medication, may produce profound sedation, respiratory depression, blood pressure drop and even death. You should inform your physician of all medications you are taking, including herbal remedies, since pain medications can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine or hydrocodone.

8. If you have a history of alcohol or drug misuse/addiction, you must notify the physician of such history since the treatment with opioids for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery is a must.

9. I am responsible for my pain medication prescriptions:
    - You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment.
    - I understand that prescription refills shall be made during regular office hours, (Monday-Thursday 8a.m.-4p.m. or Friday 8a.m.-12p.m.) and you must have a written prescription and an office visit. Refills will not be made at night, on holidays, or on weekends.
    - I understand that prescription refills shall not be made if I "run out early", or "lose a prescription" or spill or misplace my medication. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen, I will report this to the local police department and obtain a stolen item report. Replacement prescriptions will be given only at the discretion of my physician (and possibly not).
    - I understand that prescription refills shall not be made as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow". I will call at least 3 days ahead for prescription refills.
    - I understand that if my medication is replaced with a new one, I will not destroy or dispose of the excess medications. I will bring them into my physician's office for them to either exchange or dispose of the medication.

10. You are responsible for keeping your medication in a safe and secure place, such as a locked cabinet or safe. You are expected to protect your medications from loss or theft. Stolen medications should be reported to the police and to your physician immediately. If your medications are lost, misplaced or stolen, your physician may choose not to replace the medications or to taper and discontinue the medications.

11. While physical dependence is to be expected after long-term use of pain medication, signs of addiction (and psychological dependence) shall be interpreted as a need for weaning and detoxification.
    - Physical dependence is common to many drugs, such as blood pressure medications, anti-seizure medications and pain medications. It results in biochemical changes such that abruptly stopping these will cause a withdrawal.

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- Addiction is a psychological and behavioral syndrome that is recognized when the patient abuses the drug to obtain mental numbness or euphoria, when the drug is quickly escalated without the correlation to pain relief and/or when the patient shows a manipulative attitude toward the physician in order to obtain the drug. If the patient exhibits such behavior, the drug will be tapered. Such a patient is not a candidate for the pain medication trial and he or she may be discharged.
- Tolerance is a pharmacological property of certain drugs and is defined as a need for higher doses to maintain the same drug-related effect.

12. You agree and understand that your physician reserves the right to perform random or unannounced urine drug testing. If requested to provide a urine sample, you agree to cooperate. If you decide not to provide a urine sample, you understand that your doctor may change your treatment plan, including safe discontinuation of your pain medications when applicable, or complete termination of the doctor/patient relationship. The presence of a nonprescribed drug(s) or illicit drug(s) in the urine can be grounds for termination of the doctor/patient relationship. Urine drug testing is not forensic testing, but is done for your benefit as a diagnostic tool and in accordance with Florida Law on the use of controlled substances to treat pain.

13. I understand that the goals of my pain physician's treatment plan may include time-contingent use of pain medications. If it appears to the physician that there is **no improvement to my daily function or quality of life from the controlled substance, my pain medications may be discontinued.** I will gradually taper my medication as prescribed by my physician.

14. I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medicine. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

15. I further understand that if I do not follow any of the above conditions or provisions, I may, at my physician's discretion, no longer receive any type of pain medication, I also understand that if I have a problem or question with any of the above paragraphs, I must discuss this with the pain physician and receive clarification before a problem arises.

I, _____, have read the above information and I have received a copy of the agreement and all of my questions regarding the treatment of pain with possible pain medications have been answered to my satisfaction. I hereby give my consent to participate in pain medication therapy if necessary.

** The above agreement is not a guarantee of pain medication therapy, but is an understanding that if medication is prescribed to me, I will follow the above agreement.**

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Physician Signature _____ Date _____

Copy given to patient _____ Date _____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Pursuant to The Health Insurance Portability and Accountability Act (H.I.P.A.A.), 45 C.F.R. 164.508, and Florida Statute 456.057, the undersigned knowingly and voluntarily agrees to the release of any and all protected health information for any and all purposes regardless of whether any particular purpose is mentioned, including but not limited to all prescriptions including drug, dosage, and quantity; all notes regarding past, present, or future treatment; any document considered a medical record under Florida or federal law; and any other document pertaining to the treatment of the undersigned at any future date upon either request by law enforcement, the State Attorney's Office or any other prosecuting authority, or code enforcement, or at any time the physician believes that a criminal violation of federal or Florida law has occurred. The undersigned further knowingly and voluntarily agrees to waive any doctor-patient privilege and any information protected by such privilege, at any future date upon either request by law enforcement, the State Attorney's Office or any other prosecuting authority, or code enforcement, or at any time the physician believes that a criminal violation of federal or Florida law has occurred. The undersigned acknowledges that no provision for treatment, payment, enrollment in a health plan, or eligibility for benefits is a condition of this authorization. The undersigned understands that this authorization can be revoked in writing at any time unless the covered entity has taken action in reliance thereon. The undersigned understands that any released information pursuant to this authorization may be re-disclosed by the recipient and thus no longer protected under state or federal law. By signing this authorization the undersigned affirms that a signed copy of this authorization has been provided to the undersigned and understands that a signed copy of this authorization is available at any time in the future, upon request.

_____
Printed Name of patient

_____
Signature of the patient

_____
Date

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Emergency Notification/ Insurance Detail Sheet

Drivers License Number _____ MANDATORY

Workman's Compensation/Motor Vehicle Insurance Information

Employer/ Insurance Carrier _____ Phone _____

Claims Address _____

City _____ State _____ Zip _____

Claim Number _____ Date of Injury _____ Marital Status _____

Claims Adjustor _____ Phone _____ Ext _____

Attorney _____ Phone _____

EMERGENCY NOTIFICATION / NEXT KIN

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Relationship _____

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Secondary Insurance.

Dear Valued Patient,
Due to rising costs, and increasing insurance regulations we have been forced to change our policy regarding our billing secondary insurances.

We will bill your secondary insurance and submit the necessary paperwork once. If we do not hear back from your secondary insurance within 45 days, or if they deny your claim for any reason, **we will require that you pay your coinsurance and claim it back from your insurance.** This means that you will be responsible for the amount they did not pay and you will need to follow up with your insurance company for your reimbursement.

Please be aware that we will make every reasonable effort to get your secondary claims paid in the first submission.

Thank you for your understanding and cooperation

Sincerely,

Lynn R Fassy, M.D.

Patient acknowledgement:

Name: _____

Signature: _____

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Cardiac Screening Self Test

Patient Name: _____ Today's Date: _____

Dear Patient,

We have noticed an increase in the amount of patients with chronic pain who have not had the proper preventative testing to screen for heart disease and prevent complications.

Please answer the questions below so that we may provide you the highest quality care.

Please circle the correct answers.

Question	**YES**	**NO**
1. Do you have a cardiologist?	YES	NO
What is their name? _____		
2. Are you a smoker?	YES	NO
3. Do you have a family history of heart disease?	YES	NO
4. Do you have diabetes?	YES	NO
5. Do you experience leg pain?	YES	NO
6. Do you experience leg or ankle swelling?	YES	NO
7. Do you experience any chest pains?	YES	NO
8. Do you experience shortness of breath?	YES	NO
9. Are you sensitive to the cold?	YES	NO

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on 06/01/2010 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

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Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 for the first 25 pages and $0.25 for each page after the first 25 pages and the staff time charged will be $10.00 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: Pain Medicine Associates

Privacy Officer: Office Manager

Telephone: (941) 923-2500 Fax: (941) 923-2520

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Authorization for Disclosure of Protected Health Information

Information may be disclosed by: (Obtaining Records **From**)

Person/Facility: _____ Phone: _____
Address: _____

Fax: _____

Information to be disclosed to:

Pain Medicine Associates:
Lynn R Fassy, M.D.
3945 Clark Road, Sarasota, FL 34233
Telephone: 941-923-2500 **Secure Fax: 941-923-2520**

Information to be disclosed :

_____ Progress Notes (last three visits) _____ Immunizations
_____ Progress Notes (all) _____ Prenatal Records
_____ History and Physicals Records _____ Consultations
_____ Diagnostic test Results: Lab Work, Ultrasounds, X-rays Reports, MRI, CT Scans
_____ Other (specify) _____ All medical records

I specifically consent to the release information relating to:
_____ STD _____ HIV/AIDS ____ TB __X__ Drug/Alcohol __X__ Mental Heath
Purpose of Disclosure:
__X__ Continuity of Care _____ Personal Use ____ Attorney ____ Other

Expiration Date: This authorization will expire on _____. I understand that if I fail to specify an expiration date or event this will expire in 6 (six) months.
Rediscloure: I understand that once the above information is disclosure the recipient may redisclose federal privacy lays may not protect the information.
Revocation: I understand that I must do so in writing and that I must present my revocation to the medical records department. I understand that the revocation will not apply to any information that is already released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____
Patient Signature/Representative Signature Date:

_____
Printed Name

_____ _____
Witness: Date

Patient Name: _____
I.D. # _____ Date of Birth: _____