Physician Partners of America
PAIN RELIEF GROUP

Patient Information

First Name:	**Middle Name**:	**Last Name**:
DOB:	**Sex:** ☐**Male** ☐**Female**	**SSN:**
Ethnicity: ☐**Not Hispanic/Latino** ☐**Hispanic/Latino**		
Race: ☐**African American** ☐**Asian** ☐**White** ☐**American Indian/Alaska Native** ☐**Other**:		
Primary Language:		
Martial Status: ☐**Married** ☐**Single** ☐**Widowed** ☐**Divorced** ☐**Domestic Partner**		
Address:		
City:	**State:**	**Zip:**
Primary Phone:	**Cell Phone:**	**Home Phone:**
Work Phone:	**E-mail:**	

Employment Status: ☐**Employed** ☐**Retired** ☐**Student** ☐**Un-Employed**		
Employer:	**Occupation:**	**Employer Phone:**
Employer Address:		

Emergency Contact Full Name:	**Relationship:**
Primary Phone:	**Work Phone:**

Is the Patient Financially Responsible? ☐**Yes** ☐**No** **If No, Please Complete this Section**		
Relationship:	**Sex:** ☐**Male** ☐**Female**	**SSN:**
First Name:	**Middle Name**:	**Last Name**:
Address:		
City:	**State:**	**Zip:**
Primary Phone:	**Cell Phone:**	**Home Phone:**
Employer:	**Occupation:**	**Employer Phone:**
Employer Address:		

Is the Reason for Your Visit the Result of An Accident? ☐**Yes** ☐**No?**
If *Yes*, Please Complete this Section
Which Type of Accident? ☐**Workman's Comp** ☐**Automobile** ☐**Other:**
Date of Accident: **Claim #:** **Claim Adjuster:**

Insurance Company:		**Insured DOB:**
Insured/Card Holder's Name:		**Relationship**:
ID#:	**Group #:**	**Phone**:
Secondary Insurance Company:		**Insured DOB:**
Insured/Card Holder's Name:		**Relationship**:
ID#:	**Group #:**	**Phone**:

Patient Signature:_____ **Date:** / /

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TELL US ABOUT YOUR MOST SIGNIFICANT PROBLEM

How did you hear about us? ☐**Friend** ☐**Internet** ☐**Insurance** ☐**Advertisement** ☐**Other:** _____

Where is your pain located? Please list all that apply

How long has your pain been occurring?

Is your pain constant or Intermittent?

Circle all that apply to the type of pain you are feeling? Circle All That Apply

Achy Burning Dull Sharp Shooting Stabbing Tingling

Circle anything that makes the pain worse? Circle All that Apply.

Activities Bending Stretching Sitting Standing Twisting Walking

Circle any of the following that relieve the pain. Circle All that Apply.

Heat/ice packs Laying Down Pain Medication Rest Standing Sitting Stretching

What is your pain on a scale of 0-10 on TODAY? _____	**What is you pain on a scale of 1-10 on your BEST day**? _____	**What is your pain on a scale of 1-10 on the WORST day?** _____

Have you had any prior treatment for this condition? Circle All that Apply

Physical Therapy Spine Injection Anti-Inflammatory Medications Pain Medications

Bed Rest TENS unit Previous Pain Management Doctor

What recent studies/imaging have you had relating to this condition? Please Circle all that Apply.

X Ray MRI CT Scan EMG (Needle testing of Muscles) Nerve Conduction Study Discogram

Do you have a Primary Care provider? If yes, please list here.

Any other Healthcare Providers we should know about? Please list here.

_____ _____

_____ _____

PAST MEDICAL, SURGICAL, FAMILY MEDICATION AND SOCIAL HISTORY

Have you had any Sports Injuries? If yes when?

Have you ever had any broken bones? If yes when?
What bone/s?

Patient Initials:_____ **Date:** / /

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Have you ever been disabled?

Are you currently disabled? IF yes what type? **SSD** **SSI**

MUSCULOSKELETAL: Fibromyalgia Osteoarthritis Osteoporosis Rheumatoid Arthritis

CARDIAC: Cardiac Pacemaker Cardiac Stent Coronary Artery Disease DVT (blood clot)
Anemia CHF (heart Failure) Heart Attack if yes, when? Hypertension Peripheral Vascular

ENDOCRINE/Metabolic: Diabetes Mellitus Immune Disorder Thyroid Disorder

LIVER DISEASE: Hepatitis (Type: ____)

NEOPLASM: Cancer Tumor – Type_____

INFECTIOUS DISEASE: HIV Positive

PSYCHIATRIC: A.D.D. Anxiety Depression PTSD

RESPIRATORY: Asthma COPD/Emphysema Lung Disease PE Tuberculosis

UROLOGY/NEPHROLOGY: Kidney Disease Kidney Stone Prostate Issues

PAST SURGICAL HISTORY: Please list any major Surgical Procedures and Dates

_____
_____
_____
_____
_____
_____
_____

ALLERGIES: Drug/Food/Environmental

_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY: Circle All that Apply

Family History of Alcoholism Family History of Drug Addiction Heart Disease Hypertension

Stroke Diabetes Bleeding Disorder Rheumatoid Arthritis Back/Neck Osteoarthritis Asthma
Other: _____

SOCIAL HISTORY: Please answer the following about yourself

Do you Drink Alcohol: If yes #____ drinks per day/week/month
Do you have a history of heavy alcohol use or Alcoholism?

Do you have a history of drug addiction?
Do you use any street drugs? IF yes, what? Marijuana, cocaine, other: _____

Do you Smoke: If yes what? Cigar, Pipes, Cigarettes, e-Cigarettes #_____packs per day

FOR FEMALES OF CHILDBEARING AGE ONLY Many pain medication, X Rays and injections are potentially dangerous to an unborn baby. Is there any chance you may be pregnant? YES NO

Patient Initials:_____ **Date:** / /

Physician Partners of America
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MEDIC ATIONS: PLEASE LIST ALL MEDICATION CURRENTLY PRESCRIBED OR OVER THE COUNTER

Medication	Dosage	Prescribing Physician	For Which Condition

Review of Symptoms:
Have you recently experienced any of the following? Circle or mark answers below

General/Constitutional ☐Fevers /Chills ☐Infection anywhere ☐Sleep Problems	**Cardiovascular** ☐Chest Pain (any) ☐Rapid Heartbeat ☐Heart murmur	**Respiratory** ☐Shortness of Breath ☐Wheezing ☐Sleep Apnea/C-PAP/Oxygen
Gastrointestinal ☐Nausea / Vomiting ☐Constipation ☐Stomach/Abdominal Pain	**Genitourinary** ☐Kidney stone pain ☐Painful Urination ☐Blood in Urine	**Neurological** ☐ Numbness ☐ Tingling ☐ Incontinence of bladder
Muscle/Bones/ Joints ☐Muscle Spasms ☐Muscle weakness ☐Joint Pain/ extremity	**Endocrine** ☐Severe Thirst ☐Severe Fatigue ☐Decreased Sex Drive	**Psychiatric** ☐ Anxiety nervousness ☐ Feeling Sad /Depressed ☐ Suicidal Ideation ☐ Addiction to anything
Hematological ☐Easy bleeding bruising ☐Bleeding disorder/problem ☐Lymph node enlargement	**Allergy / Immunology** ☐Shellfish Allergy ☐Environmental Allergies ☐HIV	**Cancer** ☐Prostate/Colon ☐Breast ☐Lung ☐Other _____

Patient Initials:_____ **Date:** / /

Physician Partners of America
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____

DOB:_____/_____/_____ Phone Number: _____

I authorize the release of my medical records to Physician Partners of America (PPOA) for review and continuation of my medical care. I authorize the following physician offices, clinics, legal offices, diagnostic centers, and medical providers to provide copies of my health records to:

Persons/organizations receiving: (Insert Entity Name)

(List all facilities, clinics, and offices from which information may be requested)

PHYSICIAN OFFICES (please list all physicians you have seen in the past two years)

Physician Name	Address	Phone Number

HOSPITAL/OTHER FACILITIES (surgeries/procedures, radiology reports, laboratory results)

Facility Name	Address	Phone Number

Restrictions: _____ there are NO restrictions to the information that can be released
_____ the following information CAN NOT be released:

_____

DURATION: This Authorization will remain in effect: (please check selection):
_____ from the date of this Authorization until ____/_____/_____
_____ until the provider fulfill this Authorization request
_____ until the following event occurs: _____

Date:_____/_____/_____Patient/Guardian Signature _____

PATIENT PERSONAL HEALTH INFORMATION CONSENT FORM

Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, Physician Partners of America originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

Physician Partners of America's *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of the *Notice of Privacy Practices* and acknowledge that I have reviewed the notice prior to signing this consent. I understand that the Physician Partners of America reserves the right to change the *Notice of Privacy Practice at any time, and I as a patient have the right to review changes at any time*. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that the Physician Partners of America is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the Physician Partners of America has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I request the following restrictions on the use and/or disclosure of my personal health information.

_____

_____

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have reviewed Physician Partners of America's Notice *of Privacy Practices* 2023.

I acknowledge that I may request a copy of Physician Partners of America's Notice of Privacy Practices 2023, at any time.

Signature of Patient or Legal Representative,
_____Date_____

Print Name of Patient or Legal Representative _____

Witness's Signature_____Date_____

Witness's Printed Name_____

Patient Initials:_____ **Date:** / /

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Physician Partners of America (hereinafter "PPOA") and/or its affiliated entities, for any charges not covered by my healthcare benefits. It is my responsibility to notify PPOA of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill and/or balance of the bill as determined by PPOA and/or my healthcare insurer, if the submitted claims or any part of the claim are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained above, for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare if I am a Medicare beneficiary, to PPOA for all covered medical services and supplies provided to me during all courses of treatment. This includes care provided by PPOA and/or its affiliated entities or otherwise at its discretion. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with PPOA, which will authorize and allow for direct payment to PPOA, of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by PPOA.

Ownership Disclosure

I understand that PPOA is a physician-owned medical practice comprised of the offices of primary care providers, specialty care providers, and associated ancillary services. These ancillaries include, but may not be limited to, laboratory, pathology, radiology/diagnostic, physical therapy, pharmacy, and ambulatory surgery center services. During the course of my care, I may be referred to one or more of these ancillary departments. I have the right to choose where to receive these services, and I understand that I am not obligated to receive these services at a PPOA ancillary department.

_____	_____
Printed Name of Patient	Name of Guardian/Personal Representative
_____	_____
Signature of Patient	Signature of Guardian or Personal Representative

Patient Initials:_____ **Date:** / /

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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.

SOAPP®-R *Source: http://www.opioidrisk.com/node/1209*	**Patient Score:** _____ **Tech Initials:** _____	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
		0	**1**	**2**	**3**	**4**
1. How often do you have mood swings?		☐	☐	☐	☐	☐
2. How often have you felt a need for higher doses of medication to treat your pain?		☐	☐	☐	☐	☐
3. How often have you felt impatient with your doctors?		☐	☐	☐	☐	☐
4. How often have you felt that things are just too overwhelming that you can't handle them?		☐	☐	☐	☐	☐
5. How often is there tension in the home?		☐	☐	☐	☐	☐
6. How often have you counted pain pills to see how many are remaining?		☐	☐	☐	☐	☐
7. How often have you been concerned that people will judge you for taking pain medication?		☐	☐	☐	☐	☐
8. How often do you feel bored?		☐	☐	☐	☐	☐
9. How often have you taken more pain medication than you were supposed to?		☐	☐	☐	☐	☐
10. How often have you worried about being left alone?		☐	☐	☐	☐	☐
11. How often have you felt a craving for medication?		☐	☐	☐	☐	☐
12. How often have others expressed concern over your use of medication?		☐	☐	☐	☐	☐
13. How often have any of your close friends had a problem with alcohol or drugs?		☐	☐	☐	☐	☐
14. How often have others told you that you had a bad temper?		☐	☐	☐	☐	☐
15. How often have you felt consumed by the need to get pain medication?		☐	☐	☐	☐	☐
16. How often have you run out of pain medication early?		☐	☐	☐	☐	☐
17. How often have others kept you from getting what you deserve?		☐	☐	☐	☐	☐
18. How often, in your lifetime, have you had legal problems or been arrested?		☐	☐	☐	☐	☐
19. How often have you attended an AA or NA meeting?		☐	☐	☐	☐	☐
20. How often have you been in an argument that was so out of control that someone got hurt?		☐	☐	☐	☐	☐
21. How often have you been sexually abused?		☐	☐	☐	☐	☐
22. How often have others suggested that you have a drug or alcohol problem?		☐	☐	☐	☐	☐
23. How often have you had to borrow pain medications from your family or friends?		☐	☐	☐	☐	☐
24. How often have you been treated for an alcohol or drug problem?		☐	☐	☐	☐	☐

Has any relative had a problem with the following? Circle Y/N for each.

— Alcohol? Y / N
— Addiction? Y / N
— Mental Illness? Y / N

Patient Initials:_____ **Date:** / /

Physician Partners of America
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Opt In Consent

For Telephone Calls, Voicemail Transmissions, Email Messages and SMS/Text Messages.

By signing this agreement, you specifically request, expressly consent to receive, and authorize Physician Partners of America ("PPOA"), its affiliates, business associates, and service providers to deliver, or cause to be delivered, recurring telephone calls including telephonic sales calls, email messages, text messages, or voicemail transmissions. This could result in charges to you according to your phone plan for message and data rates. These calls and messages will be for health care and other purposes including but not limited to, for the purpose of treatment, appointment reminders and office closure announcements, clinic operations, telemarketing and advertising possible treatment alternatives and other health-related benefits and services that may be of interest, and for the purpose of servicing your account, payment and billing and collecting any amounts you may owe. PPOA complies with HIPAA but telephone, email, text, or voicemail messaging may not be fully secure. Reply STOP to unsubscribe from text messages at any time.

If at any point you wish to opt out of these communications, you change or obtain a new phone number, or if you no longer maintain the phone number you originally provided to us, you agree to notify PPOA immediately of such change by calling 1-800-400-PPOA (7762). Opt out of SMS/text messages can also be completed by replying STOP to any SMS/text messages sent by PPOA.

You may be held liable for failure to notify PPOA, as outlined in the following provision.

> **Indemnity Provision - *READ CAREFULLY*:**
>
> You agree to indemnify and hold the Clinic, its officers, agents and employees harmless from any liability, loss or damage, including but not limited to, attorney's fees, they may suffer as a result of claims, demands, costs or judgments against them arising out of alleged violations of the Telephone Consumer Protection Act (TCPA), Florida Telemarketing Act, or similar laws, resulting from the use of automated systems for the selection or dialing of telephone numbers, playing of artificial or pre-recorded messages placed to an incorrect or reassigned phone number(s), originally belonging to you or which you provided to the clinic, but of which you failed to timely notify the Clinic that such number(s) was incorrect or no longer assigned to you.

Opt-In

I authorize and expressly consent to receiving calls and messages to my telephone number placed by PPOA, its affiliates, associates, and service providers, using an automated system for the selection of dialing of my phone number or the playing of an artificial or pre-recorded voice message or for text messages or voicemail transmissions, for healthcare and other purposes, including treatment, appointment reminders and office closure announcements, clinic operations, telephonic sales calls, telemarketing and advertising possible treatment alternatives and other health-related benefits and services that may be of interest, and for servicing my account, payment and billing, or collecting amount I may owe. I agree to notify the Clinic immediately if I change or obtain a new phone number, or no longer maintain the phone number provided herein, and expressly acknowledge that I may be held liable for failure to do so, as outlined above.

I understand that I need not directly or indirectly sign this form or agree to enter into such an agreement as a condition to purchase any goods or services and such messages and phone calls carry certain risks.

Patient Initials:_____ **Date:** / /

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For example, messages may be sent in unencrypted form. They could be received by others if others have access to my device or if my messages are sent to another device. I understand the risks, and I expressly consent to receiving these messages and ask PPOA to communicate with me in this form.

If at any point I wish to opt out of these communications by calling 1-800-400-PPOA (7762). Opt out of SMS/text messages may also be completed by replying STOP to any SMS/text messages sent by PPOA.

I have read this disclosure in its entirety and agree that PPOA, its affiliates, business associates and/or its service providers may contact me as described above.

Mobile Phone Number: _____

Email Address: _____

Date of Birth: _____

Name: _____

Signature: _____ Date: _____

By signing below, I authorize my doctor and staff members to access my prescribed medication list through the pharmacy database, which will help my provider to deliver comprehensive care.

Signature: _____

Date: _____ Date of Birth: _____

Physician Partners of America
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Opioid Risk Tool (ORT)

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

MARK EACH BOX THAT APPLIES	FEMALE	MALE
FAMILY HISTORY OF SUBSTANCE ABUSE		
Alcohol	☐ 1	☐ 3
Illegal drugs	☐ 2	☐ 3
Rx drugs	☐ 4	☐ 4
PERSONAL HISTORY OF SUBSTANCE ABUSE		
Alcohol	☐ 3	☐ 3
Illegal drugs	☐ 4	☐ 4
Rx drugs	☐ 5	☐ 5
AGE BETWEEN 16–45 YEARS	☐ 1	☐ 1
HISTORY OF PREADOLESCENT SEXUAL ABUSE	☐ 3	☐ 0
PSYCHOLOGIC DISEASE		
ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
SCORING TOTALS		

ADMINISTRATION
- On initial visit
- Prior to opioid therapy

SCORING (RISK)
0–3: low
4–7: moderate
≥8: high

Patient Initials:_____ **Date:** / /

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Opiate Agreement

I, _____, am requesting treatment with opiate pain medication(s) because other therapies, treatments, and/or medication(s) that I have previously received and had not provided me with adequate relief of pain. I understand:

- That it is unlikely that any medication(s) will completely remove or eliminate my pain.
- Opiate pain medication(s) will be prescribed for me for humane reasons as long as my pain continues at the present level or intensity, provided that I follow all terms of this agreement/ Agreement.

My provider has discussed potential long-term opiate therapy with me in detail and I understand some of the possible complications that may occur are:

- Chemical/Physical dependence and addiction
- Severe constipation which could require medical treatment difficulty with urination.
- Drowsiness
- Nausea
- Itching
- Slow breathing or respiration.
- Reduced or absent sexual desire and/or function
- Coma
- Organ damage, failure; or death

I further understand that if I take all my medication(s) sooner than prescribed or if I suddenly stop taking my medication(s), that I could have opiate withdrawal symptoms that can be very painful and life threatening.

Female patients only: I understand that there are both known and unknown risks/ hazards to an unborn infant if the mother takes opiate medication(s). The risks/hazards include but are not limited to opiate addiction of the infant with opiate withdrawal after birth.
I assume full responsibility for notifying my provider if I suspect or confirm that I am pregnant. I further understand that a different plan of treatment, without the use of opiates, will be tried during pregnancy.

Terms/Agreements
This opiate agreement is contingent on compliance with ALL the following patient and provider terms:

- Only one pharmacy will be used at any one time for filling my opiate prescriptions. The selected pharmacy is: _____
- I agree to receive opiate medication prescriptions ONLY from the providers at Physician Partners of America, Pain Relief Group (hereinafter "PPOA")
- To obtain a refill for opiate medication(s), I understand that an appointment must be scheduled with the provider. I further understand that it is my responsibility to make sure that I have enough medication to last through the weekend, holiday and/or after hours (**5pm- 8 am**).
- I understand PPOA, Pain Relief Group does not accept telephone requests for opiate prescriptions, and I must be seen at my regularly scheduled appointment with the provider to receive an opiate prescription.
- In the case of another provider(s) on-call after hours, on holidays, and/or on weekends, he/she will **NOT** refill my medication(s). It has been explained to me that they may not have charts available for review to make decisions regarding medications.
- I agree to be under the care of a primary care provider. I will inform PPOA, Pain Relief Group if I change my primary care provider. My primary care provider is _____
- I hereby authorize a release of information that allows the providers(s) and/or staff to communicate and collaborate with any other health care provider in my care.
- I understand that at PPOA, Pain Relief Group there are many different professionals on staff who work together with a team approach to treatment plan and progress, and I give permission for the team to discuss my treatment plan and progress.
- I will notify PPOA, Pain Relief Group immediately if I experience medication side effects.
- I understand that if a serious issue effect occurs after hours, on a holiday or during the weekend, that I should immediately seek Emergency assistance from the nearest hospital.
- Prescription dosage(s) have been thoroughly explained to me by my provider and I understand that I SHALL NOT change dosage amounts and/or alter the time schedule of the prescribed medication(s) without directions to do so by my provider.
- I understand that opiate medications(s) should be kept in a safe place at all times and that I am responsible for the security of my medication. It has been thoroughly explained to me that the policy does not allow for replacement of misplaced, spilled,

inaccessible, or lost opiate medication(s) or prescription (s). I understand that if my medication(s) or prescriptions(s) are stolen that I must deliver a police report to my provider and they will contact the police for verification of the report. A second event such as above may lead to termination of this Agreement.

- I understand the benefits of opiate medications will be evaluated regularly using the following criteria:
- Increase in general level of functioning, increase in life activities, decrease in the intensity of pain, absence of unacceptable or intolerable adverse side effects, and improvement in mood.
- I agree to participate in psychotherapy sessions and psychological testing as deemed appropriate by my provider and/or the team of health care provider(s).
- I agree to submit a random urine and or/blood screens for other medications and drugs.
- I have been given information about the use of opiate medication, including possible ricks and adverse side effects such as the development of tolerance, dependence, addiction, and withdrawal and after thoroughly reviewing the information; I believe the benefits will be greater than the risks.
- I will not hoard or alter opiate prescription.
- I will not drink alcohol within 24-48 hours of taking opiate medication(s).
- I understand that a nurse may notify me of noted violations to this agreement and such notification will be considered appropriate violations in the agreement may result in Opiate Treatment Monitoring for six (6) months.
- I agree to allow PPOA, Pain Relief Group to contact other pharmacies to discuss my medications.

Opiate Treatment Monitoring:
During this period, I understand that I might have my opiate medication discontinued at any time for any reason, per a decision by my provider and the health care team. Upon notification of such discontinuance, I will be provided with a 30-day supply of appropriate medication(s). I further understand that during this period, I might be referred to an addiction specialist or to a drug detoxification program. In addition, I also realize that I might be immediately referred to an inpatient drug detoxification program and NO further medication will be provided.
I attest to the following (initial below):

_____I am not using illegal drugs or prescription drugs prescribed for someone other than myself.
_____I (**am/am not**) not undergoing treatment for substance (drugs or alcohol) dependence or abuse.
_____I have never been involved in the sale, illegal possession, or transport of drugs.

(**Female only**) I am not pregnant and I will inform the medical staff at PPOA, Pain Relief Group if I become pregnant or intend to become pregnant. I understand there may be harmful effects on an unborn infant if I take opiate medication(s). (**Initial below**).

_____ An opiate information form was provided.
_____ I have read, or had it read to me
_____ I understand the possible side effects and complications of opiate therapy.

Release
I release my provider, the team of health care providers, the team of health care providers, and PPOA, Pain Relief Group from liability for any medical and social conditions or consequences related to opiate medication(s) therapy and/or discontinuance of opiate medication(s).

Acknowledgement/Agreement
I hereby acknowledge that the content of this agreement has been explained to me. In addition, I have either read the agreement or had it read to me. I was offered many opportunities to ask questions and discuss any unclear aspects of this Agreement.

I acknowledge that I fully understand that my failure to comply with any term(S) set forth within this agreement will result in a termination of this agreement and possibly of my care and medications at PPOA, Pain Relief Group.

Patient Name:_____ **Date:**_____

Patient Signature & Date: _____

Provider Signature & Date: _____

Witness Signature & Date: _____

Physician Partners of America

504 N Reo Street, Tampa FL 33609
https://www.physicianpartnersofamerica.com/
813-549-2134 ext 2013
cpate@physicianpartnersoa.com

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We do not create or maintain psychotherapy notes at this practice.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This notice was revised and is effective as of January 1, 2023.

Carl Pate, Jr., Chief Compliance & Privacy Officer
813-549-2134 ext 2013
cpate@physicianpartnersoa.com

Physician Partners of America

Acknowledgement of Receipt of Notice of Privacy Practices

- The law requires that we ask you to state in writing that you received the notice. However, you are not required to sign the "Acknowledgement of Receipt of the Notice."
- Signing does not mean that you have agreed to any special uses or disclosures (sharing) of your health records.
- Refusing to sign the acknowledgement does not prevent a provider or plan from using or disclosing health information as HIPAA permits.
- If you refuse to sign the acknowledgement, the provider must keep a record of this fact.

Patient Name: _____ Date: _____

Patient Signature: ----------

For Office Use Only

If Patient refused to sign this "acknowledgement of receipt of the notice," please indicate reason for not signing:

_____