New Patient Information

Welcome to Valley Pain Clinic! We are pleased to be provided the opportunity to assist with the management of your chronic pain. The goals of this handbook are to answer introductory questions about our practice, review policies and procedures, and provide names and telephone numbers of staff members available to assist you.
On your initial visit to Valley Pain Clinic we will meet with you to fill out your paperwork, go over the handbook and our policies, and discuss the services we have available for management of your chronic pain

Our Philosophy

The goal of treatment at Valley Pain Clinic is to decrease your pain and improve your function. The treatment of chronic pain is not curative, it is to reduce the amount of pain you experience and help you have better control over your pain thereby improving your quality of life. We achieve this with the use of multi-modal treatment approach that ensures all the varied aspects of pain get proper attention. This expertise is comforting to patients who have tried everything. Not all pain can be completely eliminated. But for patients who hold reasonable goals and a commitment to treatment, great progress is possible toward regaining physical function and quality of life. Patients are partners who are expected to participate with integrity in their own treatment plans by providing us with your expectations of treatment and at what level of functioning or pain level you would like to be at in the future.

*****Successful Treatments and better outcomes*****

In order to have an effective treatment plans, Ultimate outcomes, and achieve long term goal that's been set by our doctors and you, It is important to receive your pain management medical treatments all in one place, therefore, ANY treatments related to your pain including but not limited to: Pain Medications, Epidural Steroid Injections, Medial Branch block injections, RF Procedures, Spinal Cord Stimulation implantation, etc.. Should be discussed with our physicians only while you are an active patient with our clinic, by seeking these types of treatments from another physician / clinic you are violating the contract with our office and your records will be transferred to your new treating physician.

Valley Pain Clinic Providers

Ahmad Shikhtholth, M.D. Board Certified Pain Management – Interventional Pain Management
Jeffrey Markham, M.D.
Shawnna Williams, CRNP

BUSINESS HOURS:
7:30AM TO 4:30PM, Monday through Thursday, (Closed from 12:00PM to 1:00PM for lunch), We are closed on all major holidays

TELEPHONE NUMBER: 256-301-9994 **FAX NUMBER:** 256-301-5545

CLINIC POLICIES

In order to better serve our patient population as a whole, we have found it necessary to put some long-standing "unwritten rules" on paper. It is our hope that by doing so, our patients will better understand the rationale behind these rules.

Opioid Agreement: In your new patient information packet you probably read and signed an Informed Consent for Opioids. This is a contract between you and Valley Pain Clinic. The purpose of the contract is not to convey mistrust, intimidate or make us appear inflexible. Rather, it is a tool used by our office to help us efficiently monitor and treat your pain. By requiring patients to call before increasing their opioid usage, we are able to assess the situation and possibly make other suggestions or order tests such as x-rays or lab work. By requiring patients to decline opioids from other providers and to use only one pharmacy, we are better able to assess your opioid usage and your needs thereby decreasing the risk of overdose. These policies also allow us to remain in compliance with State and Federal laws pertaining to prescribing opioids.

Primary Care Physician: Valley Pain Clinic is a referral service only; therefore, it is important that you have a primary care physician (PCP) prior to your first appointment at our clinic. We will inform your PCP of our treatment recommendations after your initial evaluation and of your progress thereafter. At the time of your discharge from our service, your care will be referred back to your PCP.

Medication Management Policy: The number of telephone calls received daily for early medication refills or changes in dosage has grown immensely. Please read the following before calling the office for a change in medication dosage or early refill. The main goal of treatment with opioid medications is to improve your ability to function and/or work. With that in mind, you must agree to help yourself by following a healthy way of life including exercise, weight control and limiting/ceasing the use of alcohol and tobacco.

1. It is important to take your medication exactly as prescribed. If you need to change how you take your medications, you must contact our office first. If your medications are taken other than as directed and you run out early, please do not call for a refill, as we will not be able to honor your request.
2. There are some medications that may require pre-approvals (PA's) by your insurance company. These PA's are faxed to our office from your pharmacy, where we fill them out and fax in to the insurance company. A response is usually received within 24 to 48 hours and will be sent directly to your pharmacy. Once PA's are faxed in, our office can do nothing to speed up the process nor can we make changes to the prescription at this time. Calls regarding medication PA's should be limited and directed to the nursing staff.

3. Please call your pharmacy if you need refills of your non-narcotic medication. Once you have called your pharmacy, please do not call the office. The request will be dealt with as quickly as possible.

4. We require 2-3 business days' notice when requesting a refill. It can take this long to obtain approval from your doctor. Please plan accordingly, taking holidays and weekends into consideration. Refills of opioid medications will not be made as an "emergency" because you suddenly realize you will run out tomorrow, and since all refills usually were handled during your regular office visits. You must keep track of your medications and plan ahead. **PRESCRIPTIONS WILL NOT BE REFILLED AFTER OFFICE HOURS, ON FRIDAYS OR ON WEEKENDS.**

5. Patient calls and refill requests will be taken Monday – Thursday from 8:30am to 4pm. Requests received after 4pm will be addressed on the next business day. **ALL PRESCRIPTIONS INCLUDIONG SUBSTANCE CONTROLLED PRESCRIPTIONS SHALL BE SENT ELECTRONICALLY, NOT FAXED, MAILED, OR DELIVERED TO YOUR PHARMACY.**

6. Medication changes (switching from one to another) will not be made over the telephone except in a dire emergency. Please wait until your next appointment to discuss these changes.

7. Medications will not be refilled if they are lost or stolen. This poses a safety concern to your family and our community. There will be no refills given if you did not keep your last appointment or did not make a follow up appointment as requested by your doctor.

8. Violation of the above conditions can lead to termination of your association with our clinic. If the violation includes obtaining controlled substances from another practitioner, we may also report this action to your PCP, local medical facilities and other authorities.

Compliance Contract:

The purpose of this contract is to make clear our expectations regarding appointments and behaviors. There are certain behaviors and/or actions that will not be tolerated by our office. First, we will not abide threatening words or acts. Our "zero tolerance" policy states these are grounds for immediate dismissal from this practice. Second, we can understand that problems, concerns and questions come up which require our attention. We ask that you call the office and leave a detailed message for the nurse or office staff. Messages are answered as quickly as possible. Please do not stop in to speak with a staff member without an appointment, as this will delay our interactions with patients scheduled for that day. Multiple telephone calls for the same issue will not change our response time. Problems or concerns are handled in order of severity.

EMERGENCIES

By definition, **there are no emergencies in chronic pain management.** If you have a new pain or a change in your usual chronic pain, it should be evaluated by your Primary Care Physician (PCP), or the nearest Emergency Room (ER). From time to time, you will have flare-ups (worsening) of your usual pain. This does not constitute an emergency. If you wish, you can request an earlier appointment, or to be added to our *cancellation/waiting list*, in an attempt to be seen earlier. For the most part, you should attempt to identify what brought up the exacerbation, and during your next appointment, an attempt should be made at coming up with a plan on what to do for those occasions. Walking into the clinic without an appointment, and demanding to be seen is disruptive, inappropriate, and unacceptable, and may lead to dismissal from our program.

BILLING & INSURANCE POLICIES

Cancellations and "No-Shows"

Please provide 24 hours notice in the event you should need to cancel your appointment. We ask this because we have an overabundance of patients on cancellation lists that desperately need to be seen, but cannot be, as there are no appointments available. By calling and canceling, we are able to offer your time to someone else in need. A **"no-show"** is any appointment to which you did not come and did not call to cancel. Our office policy regarding this subject states that any patient who "no-shows" 3 (three) appointments in one year will be dismissed from the practice and the patient shall be charged $30.00 for every no shows for office visits and $50.00 for Procedures at DASC.

Co-payments

Co-payments are due at the time of service. There are no exceptions. If you do not have your co-payment, your prescriptions will be held until you return with the proper amount due.

Delinquent Accounts

After your insurance has paid, the remaining balance on the account, if any, will become your responsibility. If the balance is not paid in a timely manner you will be asked to meet with our office manager. The scheduling of future appointments is contingent upon the results of this meeting. Unpaid accounts will be referred to an outside source for collection. Any unpaid balances, including bankruptcy, may lead to your dismissal from this clinic.

WHOM DO I CONTACT?

Appointments

Patients are seen by appointment only. The front office staff schedules office visits and post-procedure follow up appointments for Valley Pain Clinic. Patients coming in without an appointment will not be seen.

Scheduling Referrals and Procedures: The front office staff also schedules all referrals and procedures. Again, they work very hard to accommodate everyone. Some procedures require pre-authorization from your insurance company. One of our Billing Specialists can advise you if this is required through your particular plan.

Medical Records:

Medical records are the property of Valley Pain Clinic. It is our responsibility to keep them safe. Copies of medical records are NEVER released without a signed authorization from the patient or legal guardian. A fee will be charged to you when medical records are requested for personal use or to be sent to third parties (i.e., attorneys, insurance, disability or other sources).

Billing:

If you have any concerns or questions regarding financial matters, our billing department can assist at 256-301-8989 or on extension 111 It is far better to address your financial issues before they become problematic than to wait and let them overwhelm you. Your financial obligation to us is your responsibility and any concerns should be directed to the Billing Office and not to the medical staff.

Nursing:

Please feel free to call VPC's nurses with any questions you may have about an upcoming therapeutic injection or any complications you may be experiencing after your injection. The extension number is 104. Please leave a message and your call will be returned as soon as possible. As mentioned above, all calls will be answered in order of priority.

Management:

The Practice Manager is available to our patients who have unresolved issues surrounding their finances or medical records or who wish to report a grievance with a member of the Billing, Reception, or Medical Records staff, you can reach him on extension 111.

I_____ have read, understand, and agree to the terms of the clinic's policies and patients' information; therefore, I initialed on all the pages and signed below

Signature: _____ Date: _____

Patient Name: _____ **DOB:** _____

Please circle one number to show your response for each of the following sections

No.	Section 1- Pain Intensity	No.	Section2-Personal Care eg.Dressing,Washing
1	I can tolerate the pain I have without having to use pain medication.	1	I can take care of myself normally without causing increased pain.
2	The pain is bad, but I can manage without having to take pain medication.	2	I can take care of myself normally, but it increases my pain.
3	Pain medication provides me with complete relief from pain.	3	It is painful to take care of myself, and I am slow and careful.
4	Pain medication provides me with moderate relief from pain	4	I need help, but I am able to manage most of my personal care.
5	Pain medication provides me with little relief from pain	5	I need help every day in most aspects of my care.
6	Pain medication has no effect on my pain	6	I do not get dressed, I wash with difficulty, and stay in bed.

No.	Section 3 - Lifting	No.	Section 4 - Walking
1	I can lift heavy weights without increased pain.	1	Pain does not prevent me from walking any distance.
2	I can lift heavy weights, but it causes increased pain.	2	Pain prevents me from walking more than 1 mile. (1 mile = 1.6 km)
3	Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).	3	Pain prevents me from walking more than 1/2 mile.
4	Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.	4	Pain prevents me from walking more than 1/4 mile.
5	I can lift only very light weights.	5	I can walk only with crutches or a cane.
6	I cannot lift or carry anything at all.	6	I am in bed most of the time and have to crawl to the toilet.

No.	Section5 - Sitting	No.	Section 6 - Standing
1	I can sit in any chair as long as I like	1	I can stand as long as I want without increased pain.
2	I can sit in my favourite chair for as long as I like	2	I can stand as long as I want but it increases my pain.
3	Pain prevents me from sitting for more than 1 hour.	3	Pain prevents me from standing for more than 1 hour.
4	Pain prevents me from sitting for more than ½ an hour	4	Pain prevents me from standing for more than ½ an hour.
5	Pain prevents me from sitting for more that 10 minutes	5	Pain prevents me from standing for more than 10 minutes.
6	Pain prevents me from sitting at all.	6	Pain prevents me from standing at all.

No.	Section 7 - Sleeping
1	My sleep is never disturbed by pain.
2	I can sleep well only using pain medication.
3	Even when I take medication, I sleep less than 6 hours.
4	Even when I take medication, I sleep less than 4 hours.
5	Even when I take medication, I sleep less than 2 hours.
6	Pain prevents me from sleeping at all.

No.	Section 8 - Social Life
1	My social life is normal and does not increase my pain.
2	My social life is normal, but it increases my level of pain.
3	Pain prevents me from participating in more energetic activities (e.g., sports, dancing).
4	Pain prevents me from going out very often.
5	Pain has restricted my social life to my home.
6	I have hardly any social life because of my pain.

No.	Section 9 - Traveling
1	I can travel anywhere without increased pain.
2	I can travel anywhere, but it increases my pain..
3	My pain restricts my travel over 2 hours.
4	My pain restricts my travel over 1 hour.
5	My pain restricts my travel to short necessary journeys under 1/2 hour.
6	My pain prevents all travel except for visits to the physician/therapist or hospital.

No.	Section 10 - Employment/Homemaking
1	My normal homemaking/job activities do not cause pain.
2	My normal homemaking/job activities increase my pain, but I can still perform all that is required of me..
3	I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg., lifting, vacuuming).
4	Pain prevents me from doing anything but light duties
5	Pain prevents me from doing even light duties.
6	Pain prevents me from performing any job or homemaking chores.

This questionaire has been designed to provide VPC information as to how your pain has affected your ability to manage in everyday life.

Signature: _____ **Date:** _____

Valley Pain Clinic
2208 Danville Rd S.W. Suite G
Decatur, AL 35601
Phone: (256) 301-9994
Fax: (256) 301-5545

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION AND AUTHORIZATION OF ASSIGNMENT OF BENEFITS

We strongly feel that all patients deserve from us the very best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, **not the insurance company.** Therefore, payment for treatment is your responsibility.

Please read and sign the following:

1) I authorize this office to release or receive information necessary to expedite insurance claims.
2) I hereby authorize this office to bill my insurance company directly for their services.
3) I authorize payment directly to this physician of any insurance benefits otherwise payable to me.
4) In the event I receive payment from my insurance carrier. I agree to endorse any payment I receive over to my physician for which these fees are payable.

I understand that I am directly and fully financially responsible to this physician for charges not covered by my insurance. I further understand that such a payment is not contingent on any settlement, judgment or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay my balance in full, or there is no payments made within **60 days,** it is **my responsibility** to pay my doctors bill directly.

I further understand and agree, and if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee.

There will be a $30.00 charge on all returned checks and a $10.00 charge on all delinquent accounts, which must also be paid.

A photo static copy of these authorizations and agreement shall be as valid as the original.

Name: _____

Signature: _____ Date: _____

Valley Pain Clinic
Health Information Consent And
Acknowledgement of Notice of Privacy Practice

Consent to medical treatment:
I hereby consent to the rendering of medical care which may include diagnostic procedures, medical treatment, and possible hospital admission as considered necessary by Valley Pain Clinic **treating provider(s)** and member of their office staff.

Release of Health Information:
I authorize that my health information may be released to requesting insurance companies and/or other physicians, or medical facilities. This includes medical history, mental and physical condition, diagnosis, prognoses treatment, and reviewing necessary x-ray, lab results, etc....

I understand that Valley Pain Clinic uses and discloses patient health information to provide treatment, to obtain payment, for health care operations, and administrative purposes. By signing below, I consent to such use and disclosure of the patient's health information. I also consent to the use of disclosure of the patient's health information from which all identifying information has been removed.

I understand that before signing this consent, I have the right to review Valley Pain Clinic' Notice of information practices for more information about how my protected health information may be used and disclosed. I understand that Valley Pain Clinic may change its information practices, but before doing so, a new notice will be posted in the waiting area and each examination room. I may also call Valley Pain Clinic phone number (256) 301-9994 at any time to request a copy of the notice of information practices.

I understand that I have the right to request a restriction on certain uses and disclosures of my health information. Valley Pain Clinic is not required to agree to such restrictions, but if Valley Pain Clinic does agree, it must abide by those restrictions. I understand that I have the right to revoke this consent, in writing, except where Valley Pain Clinic has already made disclosures in reliance on my prior consent.

I understand that by signing this consent I give authority to Valley Pain Clinic to request and use my external prescription history through Prognocis, sure script, Al. PDMP. This consent will allow Valley Pain Clinic LLC to electronically prescribe medications, determine pharmacy benefits, and download a list of all medications prescribed for myself by any provider. I authorize Valley Pain Clinic to leave messages on my answering machine or text for appointment reminder and I have the right to decline receiving appointment reminder in writing for future appointments

Valley Pain Clinic LLC will grant me secure electronic access to my medical records through Prognocis patient portal "a secure website" and I have the right to activate the account, log-in to review my medications, clinical summary, or leave the account inactive.

Payment:
Payment is required at the time of the service. We will provide all the information needed to file your insurance. We will file your Medicare and any supplementary insurance after we hear from Medicare.

Insurance Payment:
I request that payment of insurance benefits be made on my behalf to Physicians of **Valley Pain Clinic** unless payment is made at the time of service. I understand that regardless of the assignment of benefits or what type of insurance coverage I have, I am responsible for any and all charges incurred by myself or my dependents. I also agree to pay **Valley Pain Clinic** the part of the fee which is not covered by my insurance plan.
I instruct my doctor to complain on my behalf to the insurance commissioner, if he deems it necessary.
I have received and read a copy of the notice of privacy practice of Valley Pain Clinic.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

VALLEY PAIN CLINIC

2208 Danville Rd. S.W. Suite G

Decatur, AL 35601

Due to federal Privacy Laws we are unable to provide information to anyone except you, the patient, regarding medical conditions, prescriptions, appointment times, or any other information held by the practice without your specific permission.

If you desire your spouse, friend, parent, etc. to pick up prescription, check on appointments, receive lab results or discuss your private medical information, please list him/her/them below and sign/date the authorization.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I, _____ Hereby authorize Valley Pain Clinic to release information from my medical records to include but no limited to my complete medical records, prescription information, appointment or visit information, x-rays and x-ray results, tests and test results, laboratory results to the above named person/persons.

I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

Valley Pain Clinic, its employees and officers and attending physicians are released from legal responsibility or liability for release of the above information to the extent authorized herein.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Valley Pain Clinic
Informed Consent for Opioid Therapy

1. It has been explained to me that the use of Opioid drugs (for example, hydrocodone, oxycodone, morphine, hydromorphone, fentanyl, tramadol, Nucynta) leads to a higher risk of accident, injury, falls, car accidents, cognitive impairment, impaired motor skills, breathing problems (including not breathing), accidental overdose and death.
2. I have been informed by my Provider that the initiation of an Opioid medication is a trial. Continuation of the medication is based on evidence of benefit to me, from associated side effects of, and compliance with instructions on the usage of the medication. I have also been informed by my physician that continuation, and any changes in dosage of the medication will be determined by pain relief, functional improvement, side effects, and adherence to usage restrictions.
3. I have also been informed that the lack of significant improvement, the development of adverse side effects, or other considerations may lead my physician to discontinue this treatment or to change dosage.

- I understand that our goal is improved function and not total relief of pain.
- I understand that the higher doses of these drugs lead to even greater risks.
- It was discussed with me that there are not good studies that show that these drugs help those with chronic pain.
- I understand that these medications may sometimes lead to dependence and misuse.
- It was discussed with me that up to 35% of people using these medications may develop addiction.
- I understand that if I have a history of addiction of any kind (including alcohol) I should not take these opioid medications.
- I understand that using Alcohol with opioids is risky and I understand that my provider may take me off opioids if he/she feels that my use of alcohol places me at risk.
- I understand that the use of certain anxiety medications, known as Benzodiazepines ("benzo"), along with opioids is dangerous and that my provider and I should avoid the use of these medications while I am receiving prescriptions for opioid medication. Example of benzodiazepines includes Alprazolam, Clonazepam, Diazepam and Lorazepam.
- I understand that the side effects of these medications may include sedation, constipation, reduced sex drive, personality changes, and falls.
- I understand that opioid medication should not be used routinely for headaches, fibromyalgia, chronic back pain, and/or Chronic Regional Pain Syndrome.
- I understand that my provider will be checking all my controlled drug prescriptions through the Prescription Monitoring Program.

- I understand that if I am on a High dose of opioids (greater than 90 Morphine equivalents daily) my provider and I will work to reduce my dosage to a less risky level.
- I understand that if I am on a High dose of opioid pain medication I will need a prescription for naloxone for treatment of overdose.
- I understand that the use of opioid medications poses special risk to women who are pregnant or may become pregnant. I know that if I plan to become pregnant or believe that I have become pregnant while taking opioid medication, I will immediately call my Obstetrician and this office to inform them. I understand that while taking this medication, the baby may become physically dependent upon opioids. I also understand birth defects can occur while taking an opioid medication. I understand that the long-term consequence on a child's development who was exposed to opioids is not understood.
- It has been explained to me that there are other treatments that do not involve the use of opioid medications. Having been informed of these risks and potential benefits, I have consented to taking the opioid medication.
- I have read this form or have had it read to me. I understand all of it. I have had a chance to have all my questions regarding this treatment answered to my satisfaction by signing this form voluntarily. I give my consent for the treatment of my pain with opioid pain medication
- I understand and agree that failure to adhere to these policies will be considered Noncompliant and may result in Cessation of opioid prescribing by my physician and possible Release from the clinic.

Patient Name: _____ Signature: _____

Date: _____

Provider Name: _____ Signature: _____

Date: _____

Valley Pain Clinic
Agreement for Opioid Maintenance Therapy

The purpose of this agreement is to give you information about the medications you will 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 opioid therapy can 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 opioids to treat pain.

1. You should use one physician to prescribe and monitor all opioid medications and adjunctive analgesics.

2. You should use one pharmacy to obtain all opioid prescriptions and adjunctive analgesics prescribed by your physician.

Pharmacy: _____Phone Number: _____

3. You should inform you physician of all medications you are currently taking, including herbal remedies, since opioid medications can interact with over-the-counter medications, and any other prescribed medications, especially cough syrup that contains alcohol, codeine, or hydrocodone.

4. You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment, plus usually two to three days extra. This extra medication is not to be used without the explicit permission of the prescribing physician unless an emergency requires your appointment to be deferred one or two days.

5. Prescriptions for pain medicine or any other prescriptions will be done only during office visits or during regular office hours. No refills of any medications will be done during the evening or on weekends.

6. You are responsible for keeping your pain medication in a safe and secure place, such as a locked cabinet or safe. You are to protect your medications and prescriptions from loss or theft. Stolen medications should be reported to the police and to your physician immediately. If your medications or prescriptions are lost, misplaced, stolen, or damaged in any way your physician will not replace the medications and/ or may dismiss you as a patient, especially if this happens more than once. We are not responsible for withdrawal that may result from you not having your medications.

7. 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.

8. Any evidence of drug hoarding, acquisition, of any opioid medication of 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.

9. You should not use illicit substances, such as cocaine, marijuana, 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.

10. The use of alcohol and opioid medications is contraindicated.

11. 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. You understand that you will be allotted 15min. to provide us with a urine drug specimen. If unable to provide one within the allotted time you understand that your appointment may be canceled and rescheduled to the next day. A urine specimen must be obtained with in 24hrs. If unable to do that, you will be given a one month supply of your medication and instructions on how to wean your self off of the medications and no future appointments will be made.

If the presences of a non-prescribed drug(s) or an illicit drug(s) are in the urine, this can be grounds for termination of the doctor/patient relationship. If the medication that is being prescribed to you by our office is not found in the urine specimen this can also be grounds for termination.
Urine drug testing is not forensic testing, but is done for your benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.

12. Physical dependence and/or tolerance can occur with the use of opioid medications.

Physical dependence means that if the opioid medication is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal physiological response. The withdrawal syndrome could include, but no exclusively, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in one's mood.

It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.

Addiction is a primary, chronic neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestations; it is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life.

Tolerance means a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain.

13. If you have a history of alcohol or drug misuse/addiction, you must notify the physician of such history since the treatment with opioid 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.

14. There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respirations (breathing).

15. 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 level along with any side effects of the medications. This information allows your physician to adjust your treatment plan accordingly.

16. In the event that you are dismissed from our practice you and all family members will be dismissed.

17. You agree to allow your physician to contact any healthcare professional, family member, pharmacy, etc. to obtain or provide information about your care or actions if the physician feels it is necessary.

18. You agree to a family conference or a conference with a close friend or significant other, if the physician feels it is necessary.

*The above agreement has been explained to me by*_____ *and I agree to its terms.*

Patients Signature_____Date_____

Witness's Signature_____ Date_____

Valley Pain Clinic

NOTICE OF INFORMATION PRACTICES

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

You have the right to obtain a paper copy of this notice upon request.

Patient health information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing and insurance information.

How we use patient health information

We use health information about you for treatment, to obtain payment, and for health care operation, including administrative purposes and evaluation of the quality of care that you receive. Before we can use the information for these purposes, we must obtain your written consent. This consent is included on a form that you have been asked to sign.
This notice gives examples of how we will use or disclose your health information for treatment, payment, and health care operation. The notice also describes circumstances when we may have to use or disclose the information even without your consent.

Examples of Treatment, Payment, and Health care operations

Treatment: We will use and disclose your health information to provide you with medical treatment or service. For example, nurses, physicians and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care provider who is participating in your treatment, to pharmacists who are filling your prescriptions, and to family member who are helping with your care.

Payment: We will use and disclose your health information for payment purposes, for example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.

Health care operations: We will use and disclose your health information to conduct our standard internal operation, including proper administration of records, evaluation the quality of the treatment, and to assess the care and outcome of your case and other like it.

Special Uses

We may use your information to contact you with appointment reminder. We may also contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you.

Other Uses and Discloser

We may use and disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your consent for the following purposes:

- Required by law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- Public Health activities: As required by law, we may disclose vital statistics, disease, information related to recalls of dangerous products to public health authorities, and similar information.
- Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
- Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.

- Law enforcement purposes: Subject to certain restriction, we may disclose information required by law enforcement officials.

- Deaths: We may report information regarding deaths to coroners, medical examiner, and funeral directors.

- Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- Military and veterans: If you are a member of the armed forces, we may release information as required by military commands authorities.

- Research: We may use or disclose information for approved medical research.

- Workers compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosure.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights:

Request Restriction: You may request restriction on certain uses and disclosures of your health information. We are not required to agree to such restriction, but if we do agree, we must abide by those restrictions.

Confidential communication: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcard to remind you of appointment.

Inspect and obtain copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend information: If you believe that information in your record is incorrect, or important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the notice currently in effect.

Changes in privacy practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and each examination. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. department of health and human services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filling a complaint.

Contact person

If you have any question, request or complaints, please contact

Ahmad Shikhtholth, MD	Medical Director
Firyad Hakim	Office Manager
Address:	2208 Danville Rd Suite G Decatur, AL. 35601
Phone No	(256) 301-9994

Effective Date: The effective date of this notice is January 11, 2011

Valley Pain Clinic

Phone (256) 301-9994

CANCELLATION / "NO SHOW" POLICY FOR APPOINTMENTS

We understand that you may need to cancel appointment due to unavoidable circumstances. As a courtesy to our healthcare professionals and to other patients, please notify us of your cancellation as soon as possible. When you do not call to cancel an appointment or a procedure in a timely fashion, you may be preventing another patient from receiving care...

Cancellation / "No Show" Policy for Appointments

Your appointment time is reserved especially for you. Should you find that you are unable to keep your appointment, please notify our office at least 24 hours in advance. This will allow us to offer your appointment slot to another patient.

- If you fail to show up for your appointment, a $30.00 fee* will be charged to your account. The same applies to appointments cancelled with less than 24 hours' notice.

- This fee is not covered by your insurance and must be paid in full prior to rescheduling your missed appointment.

- Patients who schedule and fail to keep three (3) appointments in the span of one year may be dismissed from the practice for "treatment noncompliance".

Please direct any questions regarding the Cancellation / "No Show "Policy for Appointments to the management at (256) 301-9994.

Please sign that you have read and understand the Cancellation / "No Show" Policy for Appointments.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Today's Date: _____

or Patient Representative