

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health information (**PHI**). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of your PHI. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information:

HOW WE MAY USE AND DISCLOSE YOUR PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice maintained or created in the past and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer/Practice Administrator or designee Pain Care Specialists of Oregon, LLC (503) 371-1010

WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:

*The following categories describe the different ways in which we may use and disclose your **PHI***

Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may ask you to use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a Pharmacy

when we order a prescription for you. Many of the people who work for our practice-including, but not limited to, our doctors and nurses-may use or disclose your PHI to others who may assist in your case, such as your friends or family members involved in your care.

Payment. Our practices may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits) and we may provide your insurer with details regarding your treatment to determine if your insurer will cover or pay for your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as friends or family members. Also we may use your PHI to bill you directly for services and items.

Health Care Operations. Our practice may use and disclose your PHI to operate our business. As an example of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us to conduct cost-management and business planning activities, or to train new health care workers.

Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

Release of Information to Family Friends. Our practice may release your PHI to a friend or family member who is involved in your care or who assists in taking care of you. For example, a guardian may ask that neighbor take their parent or child to the physician's office for treatment. This neighbor may have access to this patient's medical information. We may also release information to friends or family members involved in your payment for health services we provide.

Disclosures Required by Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES WITHOUT APPROVAL

The following describe unique scenarios in which we may use or disclose your PHI without consent or approval.

Public Health Risks. Our practices may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device may be using has been recalled
- Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required by law to disclose this information.
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

Health Oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and health care system in general. We may use your information to report diseases to the health department.

Lawsuits and Similar Proceedings. Our practice may disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but not only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement Concerning a death, we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court, order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or a missing person
- In an emergency, to report a crime (including the location or victim (s) of the crime or the description, identity or location of the perpetrator)

Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain:

Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For example, you may ask that we contact you at home, rather than work, or to send communications in a sealed envelope instead of a postcard. You may be asked to pay for additional costs incurred to comply with your request. In order to request a type of confidential communication, you must make written request to our Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI only to certain individuals involved in your care or the payment of your care, such as family members and friends. You may request to not have trainees or others involved in your care. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to our Privacy Officer. Your request must describe in a clear concise fashion:

- The information you wish restricted
- Whether you are requesting to limit our practice's use, disclosure or both; and
- To whom you want the limits to apply

Inspection Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Privacy Officer/Office Manager or designee, **2480 Liberty St NE, Ste 180, Salem, OR 97301 (503) 371-1010** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying associated with your request.

Amendment. You may ask to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request and amendment, your request must be made in writing and submitted to our privacy officer. You must provide it with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit in writing your request and the reason supporting your request. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosures. All of our patients have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of certain disclosures required to list your PHI as part of the routine patient care, payment, or health operations in our practice for paper records. Example of routine patient care, payment or health operations excluded from an accounting from paper charts include: the doctor sharing information with the nurse, the billing department using your information to file your insurance claim, and discussion of your PHI for purposes of improving our health care delivery system. In order to obtain an accounting you must submit your request in writing to the Privacy Officer/Office Manager or designee [2480 Liberty St NE, Ste 180, Salem, OR 97301 \(503\) 371-1010](#). All requests for “accounting of disclosures” must state a time period, which may be longer than 6 years with paper charts or 3 years for listings to include dates before April 14, 2003. The first list you request within a 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to Paper Copy of This Notice. You are entitled to receive a paper copy of our Notice of Privacy Practices. You will be offered a copy on your first visit to the practice. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact our Privacy Officer/Office Manager or designee at [\(503\) 371-1010](#).

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice, or with our Secretary of the Department of Health and Human Service; Office of Civil Rights, [500 Summer St NE, Salem, OR 97301 \(503\) 945-5944](#). All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to Provide and Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not covered by this notice or permitted by applicable law, such as for research or marketing. Any authorization you provide to us regarding the use and disclosure of your **PHI** may be revoked at any time in writing. After you revoke your PHI for the reasons described in the authorization. Please note, we are required to retain records for your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact our Privacy officer at (503) 371-1010.



PAIN CARE SPECIALISTS OF OREGON, LLC HIPAA CONSENT

By signing this Consent form, you give Pain Care Specialists of Oregon, LLC, (PCSO) permission to use and disclose protected health information about you for treatment, payment, and healthcare operation except for any restrictions specified in the 'Form to Request Restrictions'. Protected health information is individually identifiable information created or received by the practice, including demographic data, information relating to you physical or mental health, to provision of healthcare services to you, and to the collection of payment for providing healthcare services to you.

If the information to be disclosed contains any of the type of records or information for drug/alcohol diagnosis, treatment, or referral information, mental health information, genetic testing information, and HIV/AIDS information, additional laws relating to the use and disclosure of the information may apply. As the patient, you have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

The PCSO Notice of Privacy Practices provides information about how PCSO may use and disclose protected health information about you. A copy of this notice of Privacy Practices is available to you for review prior to you signing the Consent Form. As referenced in the Notice, the terms of the Notice of Privacy Practice may be changed periodically. Copies of the most current Notice will be available at your request upon check-in for you appointment or by accessing the practice's website at www.paincareoregon.com. Should you have any questions or concerns about the handling of your protected health information, you may contact the PCSO Privacy Officer at (503) 371-1010.

You have the right to request restriction on the use or disclosure of you protected health information for treatment, payment, or healthcare operations. If you request for restriction is accepted, then the practice is bound to honor that agreement.

With this consent, PCSO may call your home or alternative location and leave a message or voicemail or with an individual in reference to any items that assist the practice in fulfilling TOP, such as appointment reminders, insurance items, and any call pertaining to your clinical care, including test results. With this consent, PCSO may mail to your home or alternative location any items that assist the practice in fulfilling TPO, such as appointment reminder cards and patient statements as long as they are marked 'Personal and Confidential'.

To the extent available, PCSO may attempt to electronically obtain your prescription medication history through your insurance provider, and or prescription benefits service. By signing this Consent form, you consent to any electronic download of said information which may be useful to your treatment.

If you elect not to sign this Consent Form, PCSO has the right to refuse you treatment unless a licensed healthcare professional has determined that you require emergency treatment, or the physician is required by law to treat you. The practice is required to document any circumstances in which treatment is provided without your consent; a copy of this documentation would be available to you.

You have the right to revoke this consent in writing unless disclosure have been made based upon your prior consent. To request your revocation, you may use the 'Authorization for Release of Information Form' or you may submit a letter to the practice.

I acknowledge that Pain Care Specialists of Oregon, LLC has offered a copy of the NOPP, Notice of Privacy Practices, which includes the updated HIPAA OMNIBUS rule.

.....
Signature of Patient or Legal Representative Date



2480 Liberty Street NE, Suite 180, Salem, OR 97301
Phone: (503) 371-1010 Fax: (503) 371-0805

Patient Demographics

Name:
Address:
Home Phone: Cell Phone:
SSN#: DOB (mm/dd/yyyy):
Primary Care Physician:

Emergency Contact

Name:
Relationship: Phone:
Grant Permission to access medical information Yes No

Race and Ethnicity Survey

Please place a check indicating one choice under race and one choice under ethnicity. You are under no obligation to answer any of the questions below.

Race

- American Indian or Alaska Native
Black or African American
White
Unknown
Asian
Native Hawaiian or Pacific Islander
Decline
Other

Ethnicity

- Hispanic or Latino Ethnicity
Decline
Non Hispanic or Latino Ethnicity
Unknown

Language

- English
Russian
Indian (includes Hindi & Tamil)
Spanish
Other

Advance Directive

- Advance Directive
None on File
Do Not Resuscitate Order (DNR)

Grant Permission to leave Message

- Leave message on home phone
Leave message on cell phone*
Email message to my email address:

* Charges may be added by your carrier per your plan policy.

Name: DOB:/...../.....

New Patient Intake Form for Kiosk Check-In, Page 1 of 1

Current Medications:

Name: Dose: Frequency:

Name: Dose: Frequency:

Name: Dose: Frequency:

Name: Dose: Frequency:

Name: Dose: Frequency:

Current Medical Problems:

.....
.....
.....

Allergies: (circle all that apply)

None Tape Iodine Latex Contrast Dye Other:

Medication Allergies (list):

.....
.....

Surgical History (Circle all that apply)

Cardiac/Heart Cervical/Neck Lumbar/Back Hip Left/Right Knee Left/Right Shoulder Left/Right

Other:

Past Hospitalizations:

Date: Reason: Date: Reason:

Date: Reason: Date: Reason:

Family History: (Please place an X where applicable)

	Father	Mother	Grandparent	Sibling
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medication Tried: (please circle): Vicodin/Norco/hydrocodone/OxyContin/oxycodone/MS Contin/morphine/methadone/Dilaudid/Exalgo/hydromorphone/fentanyl patches/alprazolam/diazepam/lorazepam/Ultram/tramadol/Butrans/Opana/oxymorphone/Nucynta/Suboxone/Soma/Demerol/Tylenol 3/Tylenol/acetaminophen/ibuprofen/Aleve/Celebrex/Mobic/Voltaren/Flector patches/compound pain creams/Neurontin/gabapentin/Lyrica/pregabalin/Cymbalta/Sevella/baclofen/Flexeril/cyclobenzaprine/Zanaflex/tizanidine/Robaxin/methocarbamol/Parafon Forte/oral steroids/amitriptyline/nortriptyline/Topamax/Inderal/Botox/Other:



ASSIGNMENT OF BENEFITS FOR LABORATORY TESTING

I, the above named patient, understand that services rendered to me by Pain Care Specialists or Oregon, LLC physicians and/or other healthcare providers are my financial responsibility and that the provider will bill my insurance company, listed above, as a courtesy. I authorize my insurance company to pay my benefits directly to Pain Care Specialists or Oregon, LLC and I understand that I will be fully responsible for any outstanding balance on my account. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim. In providing this consent, I am fully aware that the physicians of Pain Care Specialists or Oregon, LLC, the staff and employees cannot be responsible for the confidentiality of the information disclosed after medical records have been released. Therefore, the physicians of Pain Care Specialists or Oregon, LLC, the staff, and employees are released from liability arising from such disclosure.

I also understand that should my insurance company send payment to me, I will forward the payment to Pain Care Specialists or Oregon, LLC within forty-eight (48) hours. I agree that if I fail to send the payment to Pain Care Specialists or Oregon, LLC and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Pain Care Specialists or Oregon, LLC to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize Pain Care Specialists or Oregon, LLC to initiate a complaint or file appeals to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

DISCLOSURE OF PHYSICIAN OWNERSHIP

The physicians at Pain Care Specialists or Oregon, LLC may have ownership in one or more of the following entities: Pain Care Specialists of Oregon and Oregon Specialists Surgery Center. A list of physician ownership is available upon request.

You have a right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than the one to which you were referred.

You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

PATIENT FINANCIAL CONSENT

Copayment is due on the day of service, unless payment arrangements have been previously arranged. Pain Care Specialists of Oregon, LLC will submit insurance claims for you. However, if the service is not covered under your policy, you are responsible for the balance due. This may include additional patient responsibility charges for procedures performed same day as office visit. It is the policy of Pain Care Specialists of Oregon, LLC to work diligently to assist patients with financial arrangements. Extended payment plans can be arranged through our billing office. These plans are based upon financial circumstances of each patient. We invite you to discuss any financial difficulties by calling our office at (503) 371-1010. If insurance requires that a referral is necessary it is the responsibility of the patient to obtain one from their primary care physician before an appointment with a Pain Care Specialists of Oregon, LLC physician. Pain Care Specialists of Oregon, LLC reserves the right to refuse service to any patient who does not have a valid referral in our office at the time of their appointment. Many of the services that our office provides require pre authorization as we ask that you be patient with our office in obtaining this authorization. Many insurance companies require documentation prior to authorizing services and we will do our best to comply in a timely fashion with their requests.

Consent to Release Information:

I (the patient/ guarantor) hereby give my consent to Pain Care Specialists of Oregon, LLC to release any information regarding my care and treatment as may be required in connection with payment. I authorize the release of any medical documentation to insurance companies and medical providers as necessary.

Assignment of Benefits:

I (the patient/ guarantor) hereby authorize payment to be rendered directly to Pain Care Specialists of Oregon, LLC for the benefits otherwise payable to me by any third party. The above authorizations are in effect permanently or until canceled by myself in writing.

Medicare Signature on File:

I (patient/ guarantor) request that payment under the medical insurance program Medicare to be made to Pain Care Specialists of Oregon, LLC on any bills for services furnished to me by the physicians of Pain Care Specialists of Oregon, LLC permanently or until this authorization is canceled by me (the patient/guarantor) in writing. I also give Pain Care Specialists of Oregon, LLC authorization to file claims to Medicare on my behalf.

Pain Care Specialists of Oregon, LLC reserves the right to charge a \$50 fee if the patient fails to give at least 24- hour cancellation notice or "no show" to their appointment. This fee will be paid by the patient/ guarantor regardless of insurance. We reserve the right to charge a \$200 fee if the patient fails to check in for a procedure or cancel the procedure without providing at least 24 hours' advance notice. This fee is not billable to insurance.

I have read this policy and understand that delinquent accounts may be assigned to a credit reporting and collection service.

CANCELLATION AND NO SHOW POLICY FOR CLINIC APPOINTMENTS

Your appointment is reserved especially for you, and when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. We also understand that delays can happen. However, in fairness to other patients, if you do not arrive 30 minutes prior to your scheduled new patient visit, or 5 minutes prior to your schedule follow-up visit, we may need to reschedule your appointment to another day. If you arrive more than 5 minutes past your actual appointment time you will be rescheduled. No controlled substances will be prescribed without an appointment. We kindly request that you notify us at least 24 hours in advance should you need to cancel or reschedule your appointment. Please contact our office between 8:00AM-4:00PM Monday through Friday at (503) 371-1010. **Each time you cancel or "no show" your appointment with less than 24 hours' notice, you will be subjected to a \$50.00 fee, and this fee is not billable to insurance. You may be dismissed from the clinic if you cancel or "no show" your appointment less than 24 hours of your scheduled time more than three times per year.**

CANCELLATION AND NO SHOW POLICY FOR PROCEDURES

Please carefully consider your procedure date before scheduling. When rescheduling has to occur, the scheduling process adds to the administrative expenses for the clinic. **If you fail to check in for your procedure, or if you cancel the procedure with less than 24 hours' notice, you will be subjected to a \$200.00 fee, and this fee is not billable to insurance. You may be dismissed from the clinic if you cancel or "no show" your appointment less than 24 hours of your scheduled time more than twice per year.**

PAIN CARE SPECIALISTS OF OREGON URINE DRUG TESTING POLICY

Opioid pain medications (also known as opiate or narcotic pain medications) are a potentially valuable source of relief for those suffering from chronic pain. They are also dangerous substances that carry the risk of bowel obstruction, liver failure, kidney failure, cardiac arrhythmia, respiratory depression and death. These medications are some of the most potentially addictive substances. Use of these medications carries risk of dependence, tolerance, withdrawals, increased pain with chronic use, depression and anxiety. The use of these substances should not be taken lightly.

Pain Care Specialists of Oregon (PCOS) providers will use a combination of factors to determine if a patient is a good candidate for opioid therapy. These factors include the patient's medical, surgical and family history. The patient will be given assessments such as the Opioid Risk Tool and the Oswestry Disability Index to make sure that the opioid therapy is appropriately treating the patient's pain.

Mixing opioid pain medications with other controlled substances can be extremely dangerous. Substances such as benzodiazepines, medical marijuana, alcohol and Soma/carisoprodol can increase the risk of complications or death in an opioid patient by up to 100%. PCSO may limit or discontinue opioid therapy in patient's taking benzodiazepines or Soma/carisoprodol.

Patients who are treated with opioid pain medications at PCSO will sign an opioid agreement. PCSO will provide no more than a 28-day supply of any opioid medication, although exceptions may be made at the discretion of the prescribing provider given very specific circumstances and discussed with colleagues. All patients are required to be physically present at the clinic to obtain a script. All new patients taking an opioid or benzodiazepine will be required to provide a urine drug test sample. This sample will undergo confirmation testing. If patients are unable to provide a urine sample, we may collect a saliva or blood sample instead. Blood or saliva samples may be sent to a specialty lab where additional charges may occur. Patient drug testing will be based on the PCSO Urine Drug Testing Algorithm and proprietary Patient Randomizing Software. Urine testing may occur at clinic visit and/or walk-in testing. Patients who are informed that a urine sample is required will have 3 days to provide the urine sample. Some patients at high doses and high risk may be required to have two (2) urine drug tests within a 30-day period. Patients may be required to provide random urine drug test samples, cognitive testing, pharmacy reports and pill counts at any time. These guidelines promote safe and appropriate patient medication use. You will be responsible for all bills associated with these required tests per your insurance benefits.

INFORMED CONSENT FORM PATIENT FOR POST EXPOSURE LABORATORY TESTS

Pain Care Specialists of Oregon, LLC is requesting your permission to have your blood drawn and tested for Hepatitis B Surface Antigen, Hepatitis C Surface Antigen, and Human Immunodeficiency Virus in case an employee or physician is accidentally exposed to your blood or contaminated body fluids. In order to establish if our employee or physician has been exposed to one of these infectious diseases, the Occupational Safety and Health Administration (OSHA) requires permission from you to perform these tests.

You will not be financially obligated for these tests.

The records of the test results will be kept confidential and are not disclosed without your written consent to any person within or outside the Center except as required by law. A copy will be provided to you at your request.

I have read the above statement and understand the importance of this lab test process for the protection of Pain Care Specialists of Oregon, LLC employees and physicians.

I do agree to have the above tests done, and I understand the test results will be acquired by Pain Care Specialists of Oregon, LLC.

By signing this form, you agree that you have read and understand the above policies.

.....
Patient of Legal Representative Name Date

.....
Signature of Legal Representative Date

.....
Patient's Date of Birth



2480 Liberty Street NE, Suite 180, Salem, OR 97301
Office: (503) 371-1010 Fax: (503) 371-0805

This authorization must be filled-out, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize to release a copy of the medical information for
(Name of Patient) (DOB)
to.....(Name of Recipient) Mailing Address
or Fax No:

The information will be used on my behalf for the following purpose(s):

By initialing the spaces below, I specifically authorize the release of the following records, if such records exist:

- All hospital records (including nursing records and progress notes)
Transcribed hospital reports
Medical records needed for continuity of care
Most recent five year history
Laboratory reports
Pathology reports
Diagnostic imaging reports
Clinician office chart notes
Dental records
Physical Therapy records
Emergency and urgency care records
Billing Statements
Other

Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

- *HIV/AIDS-related records
*Genetic testing information

*Must be specifically selected to be included in other documents.

- **Drug/Alcohol diagnosis, treatment or referral information

**Federal Regulation 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.

- This authorization is limited to the following treatment:
This authorization is limited to the time period:
This authorization is limited to a worker's compensation claim for injuries of:

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization, unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Signature of patient

Date

Signature of person authorized by law

Date



2480 Liberty Street NE, Suite 180, Salem, OR 97301
Office: (503) 371-1010 Fax: (503) 371-0805

PERMISSION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION TO A FAMILY MEMBER, FRIEND OR LEGAL REPRESENTATIVE

IMPORTANT NOTE: The law prohibits release of confidential Medical information to any entity without the written, voluntary consent of the undersigned patient.

Name of Patient: Date of Birth:

I give permission for Pain Care Specialists of Oregon, LLC, or their designated representative to communicate information about my medical condition and treatment to:

Form with four rows for listing family members, friends, or legal representatives, with columns for Name, Phone, and Relationship.

Printed Name of Patient Signature Date

Printed Name of Representative Signature Date