Mississippi Sports Medicine

And Orthopaedic Center

Thank you for choosing Mississippi Sports Medicine And Orthopaedic Center for your care and treatment. Please complete the enclosed forms and bring them with you when you arrive for your appointment.

KINDLY BRING COMPLETED FORMS WITH YOU. DO NOT MAIL. THANK YOU!

If you need to cancel or reschedule your appointment, please call us at (601) 354-4488 at least 24 hours in advance. There is a $30 fee if you do no cancel or reschedule your appointment with proper notice.

Please arrive 15 minutes prior to your appointment, if you have finished all paper work. If you DO NOT have your paperwork completed, please arrive 30 minutes prior to your appointment.

Please bring your picture I.D. and insurance cards along with these completed forms. Any applicable co-pays or coinsurance will be collected at the time of service.

Please bring a list of all medications that you are currently taking, X-rays, MRI films, or any other medical records that may be pertinent to this visit.

If this visit is due to an accident that is covered by workers' compensation, please have your employer or adjuster furnish the name, injury date, workers' compensation carrier name, claim number, billing address and phone number. These are required for your visit.

Important Insurance Information

Our staff is here to help ensure your claims are paid in a timely manner. Please take a minute to read the information below to assist us to get your claims paid.

- If your visit is due to an injury, your insurance company may require additional information from the patient. Your insurance company will mail the patient or the guarantor a form to fill out. If this form is NOT filled out, the claim is usually denied pending this information and will be the patient's responsibility. You should receive this request within 30 days of your visit.
- If you do not receive an injury form or an explanation of benefits (details on what has been paid or denied by your insurance company) please contact your insurance company.
- If your injury is due to an auto accident, we will need a letter from your auto insurance stating you have exhausted your medical pay. We will need this letter to file your claim to your health insurance.
- Please let our front desk personnel know if your insurance has changed since your last visit with us. Keeping us informed of any changes will help us in filing your claim correctly and in a timely manner. Please always use your complete legal name. If your name on the insurance card and the name you give us DO NOT match, we will not be able to file your claim.

Notice Of Privacy Practices For Protected Health Information

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

Mississippi Sports Medicine and Orthopaedic Center is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this notice of our legal duties and privacy practices with respect to protected health information. Mississippi Sports Medicine and Orthopaedic Center is required by law to abide by the terms of this notice, and we reserve the right to change the terms of notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this notice, we will post a revised notice at the hospital and/or clinic and will make paper copies of this notice or Privacy Practices for Protected Health Information available upon request.

How Your Medical Information Will Be Used And Disclosed:

We will securely store your medical information on a computer for use as part of rendering patient care. For example, your medical information may be used by the health care professional treating you, by the business office to process your payment for the services rendered and by the administrative personnel reviewing the quality and appropriateness of the care you receive.

We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation or determination or the Hospital's compliance with relevant laws.
- Unless you object, we will include general information, including your name, location in the clinic, your condition described in general terms and your religious affiliation in a directory of individuals located in the clinic. The directory information, except for your religious affiliation, will be released to people who ask for you by name. Your religious affiliation may be given to members of the clergy, even if they do not ask for you by name.
- Unless you object, we may disclose to family members, other relatives or close personal friend the medical information directly relevant to such person's involvement with your care.
- Unless you object, we may use or disclose your medical information to notify a family member, a personal representative or another person responsible for your care of your location, general condition or death.
- We may disclose your medical information to a public or private entity for the purpose of coordinating with that entity to assist in disaster relief efforts.

- We may use or disclose your information for public health activities, including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.
- We may disclose your medical information in the course or certain judicial or administrative proceedings. We may disclose your medical information for law enforcement purposes or other specialized government functions.
- We may disclose your medical information to a coroner, medical examiner or a funeral director.
- If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.
- We may disclose your medical information for certain research purposes.
- We may use or disclose your medical information to prevent or lessen a serious threat to health or safety or another person or the public.
- We may disclose your medical information as authorized by laws relating to workers' compensation or similar programs.

We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time.

Your Rights Regarding Your Medical Information:

You have the following rights with respect to your medical information.

- The right to request restrictions on certain uses and disclosures of your medical information. We are not required to agree to your requested restriction, but if we do, we will honor it.
- The right to receive communications from us in a confidential manner.
- The right to inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
- The right to request an amendment of your medical information. We may deny your request for certain specific reasons, and, if denied, we will provide you with a written explanation for the denial and information regarding further rights you would have at that point.
- The right to receive an accounting of the disclosures of your medical information made by the clinic in the six years prior to your request, except for disclosures for treatment, payment or clinic operational purposes, and for other certain specifications disclosure types.

- The right to request a paper copy of this notice of Privacy Practices for Protected Health Information.
- The right to complain to the clinic and/or to the United States Department of Health and Human Services if you believe that Mississippi Sports Medicine has violated your privacy rights. If you choose to file a complaint you will not retaliated against in any way.

If you would like further information regarding your rights or the uses and disclosures of your medical information you may contact our administrator.

Mississippi Sports Medicine And Orthopaedic Center, PLLC
ATTN: Glen Silverman, CEO
1325 East Fortification Street Jackson MS 39202
Phone: 601-354-4488
Fax: 601-914-1849

Patient Acknowledgement of Receipt of Notice of Privacy Practices

Patient Signature: _____

Mississippi Sports Medicine & Orthopaedic Center, PLLC
& the Therapy Center for Mississippi Sports Medicine

Patient Demographic & Insurance Information

Today's Date: _____

Patient Legal Name: _____ Account #: _____
First Name Last Name

Mailing Address: _____
Address City State Zip

Same as above ❑
Billing Address: _____
Address City State Zip

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Patient SSN: _____ - _____ - _____ Gender: ❑ Male ❑ Female Age: _____ DOB: _____ /_____ /_____

Responsible Party Demographic Information

Same as above ❑

Patient's Relationship to Responsible Party: ❑ Self ❑ Child ❑ Spouse ❑ Guardian ❑ Other: _____

Name of Responsible Party: _____ Gender: ❑ Male ❑ Female

Mailing Address: _____
P.O. Box City State Zip

Same as above ❑
Billing Address: _____
P.O. Box City State Zip

SSN: _____ - _____ - _____ DOB: _____ /_____ /_____

Policy Holder Primary Insurance

Insurance Name: _____

Employer : _____

Group Name / #: _____

Policy Number: _____ SSN: _____ - _____ - _____

Relationship to the Patient: _____

DOB: _____ /_____ /_____ Eff. Date: ___ / ___ / ___
MM D YY

Policy Holder Secondary Insurance

Insurance Name: _____

Employer : _____

Group Name / #: _____

Policy Number: _____ SSN: _____ - _____ - _____

Relationship to the Patient: _____

DOB: _____ /_____ /_____ Eff. Date: ___ / ___ / ___
MM D YY

I hereby authorize payment directly to Mississippi Sports Medicine and Orthopaedic Center, PLLC, for medical services rendered. I authorize the release of my medical information deemed necessary in the processing of a claim. It is my understanding that I am responsible for this amount, regardless of insurance coverage.

I have received a copy of Mississippi Sports Medicine and Orthopaedic Center's Privacy Policy.

Date: _____ /_____ /_____ Signature: _____

Emergency Contact Information/HIPAA Release

Name: _____ City: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Relationship to Patient: _____

Would you like to permit the above individual or any other individual to receive information regarding medical and/or billing questions? ❑ Yes ❑ No

Additional Individual Name: _____

Relationship to Patient: _____

Patient Signature:_____

Physician Disclosure of Financial Interest

Notice to patients treated by Mississippi Sports Medicine and Orthopaedic Center, PLLC:

Both Federal and Mississippi law requires that your physician disclose to you any financial interest he or she may have in an entity to which you may be referred, so that you may address any concerns you may have directly with your physician.

Your referring physician is an owner of Mississippi Sports Medicine. This notice is to let you know that Mississippi Sports Medicine owns its own MRI Services, CT Services, and the Flowood Surgery Center. The physician owners may refer you for additional services needed to diagnosis, therapeutically treat, or surgically repair your medical condition to one of these entities listed above.

By signing the below, you acknowledge your receipt of this Physician Disclosure of Financial Interest and understand that your referring doctor is an owner of this facility. A list of alternative facilities can be provided to you upon request.

Patient Signature:_____

❑ I agree to receive future email correspondence to this email address: _____

❑ I agree to receive future SMS/Text messages to this number (messaging charges may apply if your cell phone rate plan does not include SMS/text messages: _____-_____-_____

Date: ____/____/____ Print Name: _____ Signature: _____

Please sign and date only if you opt-in to receive text or email correspondence

The Pain Institute
AT MS SPORTS MEDICINE

PAIN EVALUATION

Date of Appt.

Name (Last, First, Middle)

Referring Physician

Current Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed | How Long?

Number of Children Ages of Children

What is your Specific Occupation – Including Housewife (Briefly describe what you do)

Are you presently employed? ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Disabled | If unemployed/disabled, how long?

If you are Unemployed, or employed Part-time, is this due to your present Pain Condition? ☐ Yes ☐ No

How long have you been working for your present employer? (or last employer if unemployed, disabled, retired, etc.) YES NO | Years

Is this a work related injury? ☐Yes ☐ No

Have you attempted to return to work? Yes No | If yes, did you work ☐ Full Time ☐ Part Time

Did your employer allow you to return? ☐ Yes ☐ No

Do you take a blood thinner? Coumadin, Warfarin, Plavix, Lovenox, etc. ☐Yes ☐ No

If female, could you be pregnant? ☐Yes ☐No

Do you have a bleeding disorder? ☐Yes ☐No

Do you currently have an infection? ☐Yes ☐No Are you on antibiotics?

Have you had an MRI or CT to the area where you having pain in the last 5 years? ☐Yes ☐No

If so where?

Have you ever seen another pain management physician? ☐Yes ☐No

If so who and where?

When did the pain start?

Does the pain travel to any other part of your body?

On a scale of 1-10, how bad is your pain?

Is your pain worse at any time of the day?

What makes your pain better?

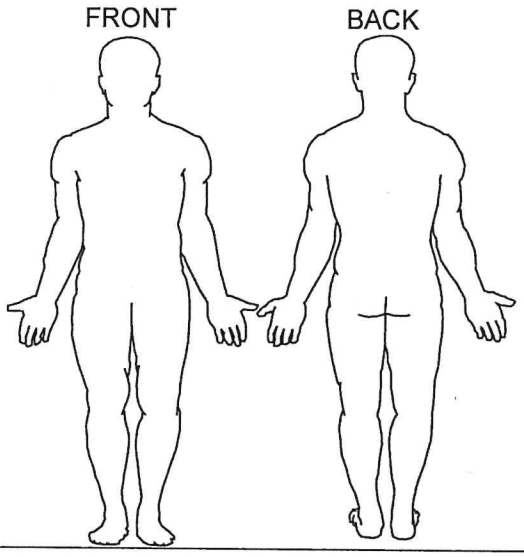
What makes your pain worse?

What medication have you taken for your pain?

Have you tried any physical therapy or exercise?

Have you ever had any nerve blocks? And by whom?

Mark on the drawing the exact spot where your pain is. Mark this with a solid dot (.) If the pain starts at that spot and radiates elsewhere (travels to another part of your body), draw a line from the spot where it stars to where it ends. If it is a whole area that hurts, shade in that area.



PLEASE CIRCLE THE APPROPRIATE WORDS THAT DESCRIBE YOUR PAIN

Aching	Shooting	Dull	Constant
Burning	Tingling	Tight	Radiating
Cramping	Hotness	Heavy	Annoying
Numbness	Coldness	Intense	Severe
Stinging	Soreness	Brief	Unbearable
Stabbing	Sharp	Transient	Excruciating

REVIEW OF SYSTEMS

Please circle any of the following problems that apply to you now in the past 3 months

General:	weight loss	weight gain	fatigue	
Respiratory:	hemoptysis	shortness of breath	wheezing	
Cardiovascular:	ankle edema	chest pain	palpitations	
Gastrointestinal:	abdominal pain	blood in stool	vomiting	reflux
Neurological:	numbness uncoordination	tingling in legs/arms bowel/bladder control	headaches sensory alterations	seizures weakness
Musculoskeletal:	gait abnormalities	muscle pain	joint swelling	
Skin:	rash	sores/abscess	itching	
Hematologic:	bleeding tendencies	easy bruising	swollen lymph nodes	
Psychologic:	mood swings	agitation	anxiety	

PAST MEDICAL HISTORY

Please Circle all that Apply to you

Glaucoma	High Blood Pressure	Asthma	COPD(emphysema)
Stroke	Pulmonary Embolus	Breast Cancer	Diabetes Mellitus
Heart Failure	Kidney Stones	Lung Cancer	Tuberculosis
Depression	Hiatal Hernia(GERD)	Lymphoma	Thyroid Disease
Arthritis	Seizure Disorder	Hepatitis	Pancreatitis
HIV/AIDS	Prostate Enlargement	Anemia	Prostate Cancer
Meningitis	Hiatal Hernia	GI Bleeding	Stomach Ulcers
Leukemia	Peptic Ulcer Disease	Liver Disease	Any Mental Illness
Fibromyalgia	Irritable Bowel Syndrome	Chronic Joint Pain	Migraine Headaches
Chronic Sinusitus	Recurrent Kidney Infections	Sleep Apnea	Interstital Cystitis

Medications

Please list for what illness or problem

MEDICATION	DOSE	FREQUENCY	DATE STARTED

Please list ALL allergies:

Please list ALL previous surgeries and the approximate date. (Use back for additional space)			
	FAMILY HISTORY		
Does anyone in your family have a similar problem?		☐Yes	☐No
Are there any hereditary diseases in your family?		☐Yes	☐No
If yes, please list:			
List any major medical problems in your family:			
Do you smoke?	☐Yes ☐No	If so, how many packs per day?	
Do you drink?	☐Yes ☐No	If so, how much per day?	
Illicit drug use?	☐Yes ☐No		
Your Height:		Your Weight:	

The Pain Institute
AT MS SPORTS MEDICINE

PAIN MANAGEMENT CONTRACT

Your provider may choose medication therapy for your treatment. You must read and sign this contract with before medication will be prescribed. This agreement is to give you information and guidelines regarding the medications that may be prescribed for pain management, and to assure that you, as well as this office, will comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderated to severe chronic pain with the intent of reducing pain and increasing daily function. Our 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 MUST** use only The Pain Instutute providers to prescribe all pain medications.
2. **You MUST** only use <u>one</u> pharmacy to fill all pain medication prescriptions.
3. **You MUST** inform your physician of all medications you are taking, including herbal remedies, since opioid medications can interact with over-the counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine or hydrocodone.
4. **You MUST** fill prescriptions <u>only on the fill date listed on your prescriptions.</u> You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment. <u>NO UNAUTHORIZED INCREASES IN MEDICATIONS WILL BE TOLERATED.</u>
5. Prescriptions for pain medication or any other prescription, as well as medication refills will be done only during an office visit or during regular office hours. PRESCRIPTIONS AND/OR REFILLS CANNOT BE CALLED IN.
6. JAPC uses the online **<u>MS PRESCRIPTION MONITORING PROFILE (MS PMP) REPORT</u>** to be able to monitor when you fill your prescriptions, where they are filled, how you pay for them, as well as any prescriptions you may have filled by other physicians. Any discrepancies, whether it is with our prescriptions or any you may have filled from others physicians, could void this contract and result in no longer being eligible to receive medications from our office.
7. **<u>On each office visit</u>** a urine drug screen will be **required** to continue your medication treatment. This will test to make sure you are properly taking our medications as we have prescribed them for you, and that you are NOT taking any other type of pain medication or any illicit substances. You will also be subject to be called in for unannounced random urine drug screen at any time. Failure to comply with this will void this agreement and result in not receiving medications from The Pain Institute.
8. **<u>On each office visit</u>** you must bring all original medication bottles prescribed by The Pain Institute with remaining pills left in the bottle. We may do a pill count to assure that the prescribed medications are being taken as directed.
9. **<u>You are responsible</u>** for keeping your pain medication in a <u>safe and secure place,</u> such as a locked cabinet or safe. This is for your safety as well as your families'. You are expected to protect your medications from loss or theft. **<u>Medications that are lost,</u>**

misplaced or stolen will NOT be replaced.

10. **You CAN NOT** give or sell your medications to any other person under any circumstance. If you do, you may endanger that person's health, and it is also against the law and will be reported. This will void this contract and result in no longer receiving any medications from The Pain Institute.
11. If there is **ANY** evidence of drug hoarding, receiving pain medications from other physicians (which includes emergency rooms or dentists), doctor shopping, selling or diverting (giving) pain medication to others, prescription forging or altering of prescriptions, or any other pain medication abuse will result in termination of the doctor/ patient relationship and **ALL illegal offenses will be turned in to the proper law enforcement authorities.**
12. You will communicate fully to your physician to the best of your ability at the initial and follow-up visits your pain level and functional activity along with any side effects of the medications. This information allows the physician to adjust your treatment plan accordingly.
13. **You must NOT use ANY illicit substances**, such as cocaine, marijuana, or others while taking these medications. This will result in a change to your treatment plan, including safe discontinuation of your opioid medications and/or complete termination of the doctor/ patient relationship.
14. You must NOT use alcohol while taking pain medications.
15. 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 state) and / or motor ability. Overuse of opioids can cause decreased respiration (breathing).
16. **Physical dependence and / or tolerance** can occur with the use of opioid medications.
    Physical dependence means that if the opioid mediation 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 not exclusively, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in one's mood.
    Tolerance means a state of adaptation in which exposure to the drug induces changes that result in reduction 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.
17. **Addiction** can occur with the use of opioid medications.
    Addiction is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. 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.
18. **If you have a history of alcohol or drug misuse/ addiction, you must notify the provider of such history since the treatment with opioids for pain may increase the possibility of relapse**. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery is a must.
19. **Our clinic has a zero tolerance for verbal abuse towards our staff. Swearing, yelling at, or threatening of our staff will result in immediate termination from our clinic.**

By signing below, I've read, understand and agree to the Pain Management Contract agreement with The Pain Institute. It has been explained to me by my provider, and I fully agree to its terms so that they can provide quality pain management using opioid therapy to decrease my pain and increase my function. I understand any deviation from this contract will result in no longer being a candidate for Pain Medication therapy with The Pain Institute at MSMOC.

Patient's Signature _____

Date _____

Pharmacy _____

Pharmacy phone number _____

Witness's Signature _____

Date _____