JAFFE ETHICAL ADDICTION AND PAIN CARE LLC: HIPAA COMPLIANT MEDICAL RECORDS RELEASE REQUEST

Patient's Name_____Date of Birth_____

Address_____ Social Security No:_____

Medical Records: I hereby authorize _____("Releasor") to disclose the following:

[ ]-**ALL Medical Records,** I request the release of my complete health record, which may or may not include protected health information (PHI) and electronic protected health information (ePHI) protected under HIPAA.

[ ] Restrictions- Medical information relating to diagnosis and treatment of alcohol or drug abuse, mental illness, STD's, or HIV/AIDS shall [ ] Be included [ ] Not be included.

[ ] Limitations/ Specific Medical Records:_____

Recipient: My medical records shall be disclosed to the following Individual/Entity:

Todd B. Jaffe MD/ Jaffe Ethical Addiction and Pain Care LLC. 928-892-5776 Phone

4830 SR Hwy 260 Suite 103, Lakeside, AZ 85929 928-495-5514. Fax

Email: info@jaffepaincare.com

Purpose of Release: Transfer of care, permanent. Expiration: This authorization expires after production of all records requested.

I understand that signing this authorization is voluntary, and that my treatment will not be conditioned upon whether I sign this authorization. I also understand that I have the right to revoke this authorization at any time by writing to the Releasor, except where disclosure may have already been made based upon my original permission. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

_____ _____

Patient or Authorized Representative Signature Date of Signing

_____

Printed Name

Authorized Representative Relationship to Patient (if not Patient)

JAFFE ETHICAL ADDICTION AND PAIN CARE LLC

Patient Demographics

Purpose of this form: To have your information on file to: identify you in our office, to have an emergency contact on record, to contact your doctors and insurance companies for information used in your treatment and billing, and to identify your preferred pharmacy.

Patient Information

First Name _____ MI _____ Last Name _____

Birth Date _____ Age _____ Sex _____ Social Security _____

Marital Status _____ Home Phone # _____

Cell Phone # _____ Work Phone # _____

Home Address _____ City _____

State _____ Zip Code _____ Email _____

If you have a resuscitation limitation, please provide us with documentation. Otherwise, all patients are considered for resuscitation in an emergency.

Race [ ] White [ ] American Indian/Alaskan Native [ ] Native Hawaiian/Pacific Islander

[ ] Black/African American [ ] Decline to specify

[ ] Other

Ethnicity/culture/heritage [ ] _____ [ ] Decline to specify

Primary Language [ ] English [ ] Spanish [ ] Other

Emergency Contact Information Person Name and relationship _____

Phone Number _____

Primary Care Physician

Name _____ Phone Number _____

Referring Provider Information

Name _____ Phone Number _____

How did you hear about us?

Claims

Do you have an open Workers Compensation claim related to this visit? [ ] Yes [ ] No

Do you have an open car accident injury claim related to this visit? [ ] Yes. [ ] No

JAFFE ETHICAL ADDICTION AND PAIN CARE LLC

Pharmacy

Name _____ Phone Number _____

Insurance Company #1 Policy # Group # Phone #

Insurance Company #2 Policy # Group # Phone #

Name of Present Pain Management physician _____

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_____ _____

Patient or Authorized Representative Signature Date of Signing

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Printed Name

_____

Authorized Representative Relationship to Patient (if not Patient)

New Patient

Form No Meds

JAFFE ETHICAL ADDICTION AND PAIN CARE

Patient Medical History **Todays Date**

Purpose of this form: To gather personal and medical information that will help us understand and plan for your visit.

Please check the appropriate boxes. Thank you.

Last Name _____ First Name _____ Birth Date _____ _____ _____

Reason for „Visit

	Right	Left	Middle
[ ] Back Pain	[ ]	[ ]	[ ]
[ ] Neck Pain	[ ]	[ ]	[ ]
[ ] Leg Pain	[ ]	[ ]	[ ]
[ ] Arm Pain.	[ ]	[ ]	[ ]
[ ] Stroke	[ ]	[ ]	[ ]

[ ] Other _____

Describe your pain

[ ] Shooting paln [ ] Burning pain [ ] Numbness [ ] Weakness
[ ] Tingling [ ] Sharp pain [ ] Stabbing pain

When did the problem start? _____

How did the problem start? _____

Has the problem recently gotten worse? _____

Did this injury occur as a result of an accident or at work?. _____

What treatments have you had for this problem? (Please explain)

[ ] Physical Therapy _____

[ ]Chiropractic

[ ] Medications that have helped

[ ] Medications that have NOT helped _____ _____

[ ] Injections _____ _____ _____

[ ] Surgery _____

[ ] Other _____

Allergies Please list any allergies you may have

_____

_____

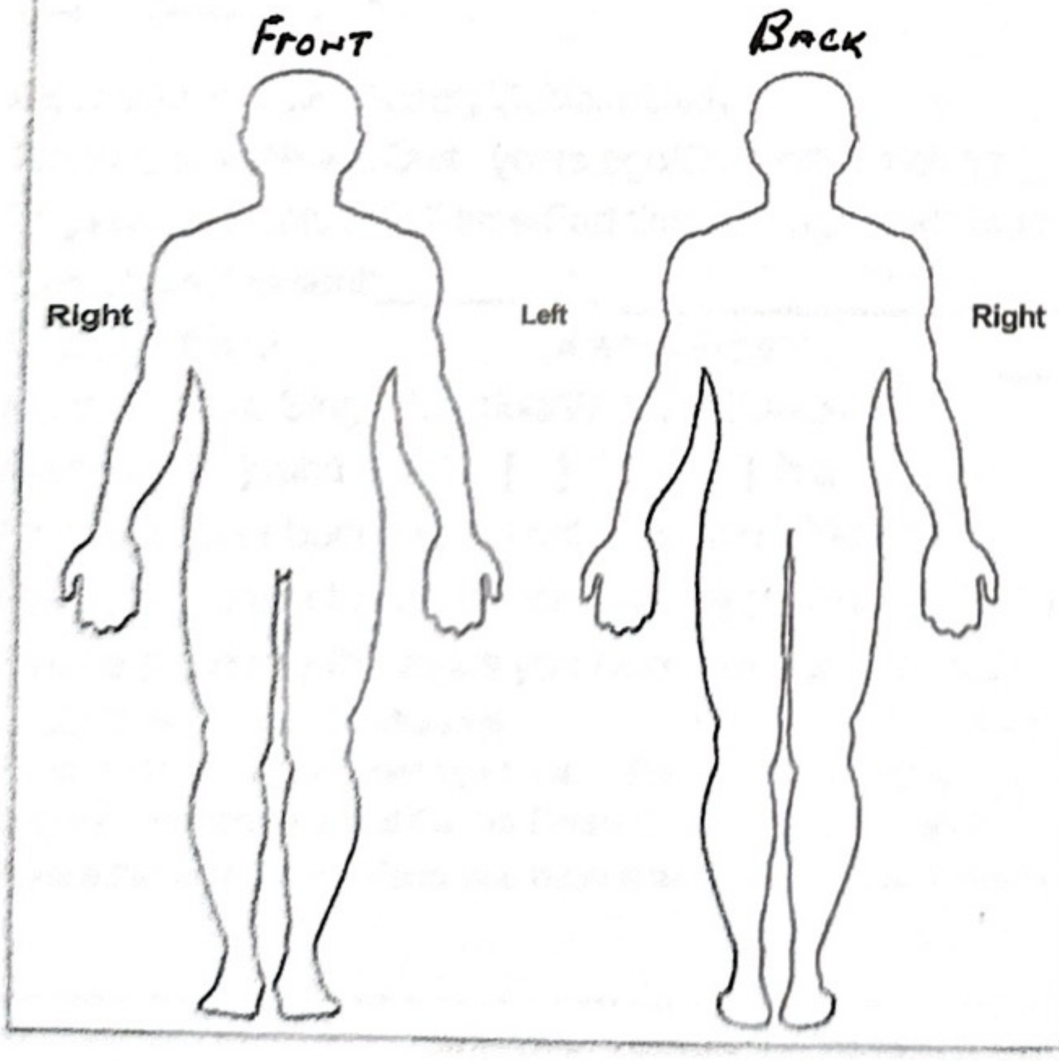
[ ] No Known Drug Allergy

JAFFE ETHICAL ADDICTION AND PAIN CARE LLC

Pain Assessment Sheet

Name				Date	
Current Complaints					
Progession of your current condition since it started	[ ] Same	[ ] Improved	[ ] Worse	[ ] Other	
Does yourpresent condition affect your daily activities at home or in the office? -Describe:					

Type of pain						
[ ] Sharp	[ ] Tingling	[ ]Throbbing	[ ]Numbness	[ ] Aching	[ ] Shooting	[ ] Dull
[ ] Burning	[ ] Cramping	[ ] Stiffness	[ ] Swelling	[ ] Other		
Other comments and notes:						



Describe the areas where you feel pain and provide as Much detail as possible. Mark the body outline to indicate location of pain.

JAFFE ETHICAL ADDICTION AND PAIN CARE LLC

New Patient No Drugs Form

Name and DOB:_____

Primary care Doctor/Phone number: _____ **Pharmacy name/Address/Phone** _____

Drug allergjes: _____

Current medications

Medication	Strength	Directions	Prescriber

***********If medications exceed provided space please attach a current medication list**********

Social history:

Alcohol use: Never/Rarely/Socially/Daily Past drug abuse: Any history? Yes/No _____

Tobacco use: Never/Quit years ago/Currently smoking _____ packs per day for _____ years.

Employment status: Full time/Part time/Unemployed/Retired/Disabled.

Type of employment:_____ _____

Exercise: None x/week Type: _____

Marital status: Single/Married/Widowed/Divorce **Children**: _____

Medical Marijuana card? [ ] Yes [ ] No

Have you ever been in pain management? Yes/No Physician _____

Have you completed a physical therapy program? Yes/No When _____

Please circle any therapies you have tried for your pain:

Acupuncture Massage Chiropractor Support brace Tens unit Epidural injections
Facet blocks Trigger point injections Botox Radiofrequency Ablations Gel Injections Stellate Ganglion block
Surgery Implanted Spinal Cord or Dorsal Root Ganglion Stimulator Implanted pain pump

Please list any medications you have tried *for* you pain; Circle the ones that have been helpful

_____

_____

_____

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Medical history

Condition	No	Yes/Please explain
Asthma/COPD		
Arthritis		
Anxiety		
Depression		
Hepatitis		
Liver disease		
Kidney disease		
Hypertension		
Thyroid disorder		
Cardiac conditions		
Stroke		
Diabetes Mellitus		
HIV/AIDS		
Genetic conditions		
Cancer		
Auto immune		

Any other medical history:

Surgical history

Procedure	Date	Physician

Family history:

Mother:

Father:

Siblings:

Children:

Maternal grandparents:

Paternal grandparents:

Any family history of alcoholism or drug abuse?

JAFFE ETHICAL ADDICTION AND PAIN CARE LLC

Review of Systems

Please circle all that apply

General

Weight gain Weight loss Fatigue Fever or chills Weakness Difficulty sleeping Enlarged lymph nodes

Other: _____

Skin

Rashes Lumps Itching Dryness Color changes Hair loss Nail changes MRSA

bruising open wounds

other: _____

Ears/Nose/Throat

Decreased hearing Ringing in ears Earache Stuffy nose Runny nose Nose bleeds

Dry mouth Sore throat Hoarseness

Other: _____

Neurologic

Headache Dizziness Fainting Seizures Numbness Tingling Tremors

Confusion Stroke Paralysis Forgetfulness Difficulty concentrating

Cardiovascular

Chest pain/discomfort Swelling Palpitations Dizziness Irregular rhythm

Fatigue Bleeding complications Clotting complications

Respiratory

Cough Sputum Shortness of breath Painful breathing Coughing up blood

Wheezing

Other: _____

Musculoskeletal

Muscle pain Joint pain Stiffness Redness of joints Swelling of joints

Neck pain Back pain

Other: _____

Gastrointestinal

Difficulty swallowing Heartburn Change in appetite Nausea Vomiting

Diarrhea Constipation Flatulence Abdominal pain

Other: _____

Continues on back, turn over to other side

JAFFE ETHICAL ADDICTION AND PAIN CARE LLC

Review of Systems

Please circle all that apply

Urinary.

Frequency Urgency Burning/pain Blood in urine Incontinence Other: _____

Psychiatric

Stress Anxiety Depression Mood Changes Memory loss Substance abuse

Post-traumatic Stress Disorder. Psychosis Attention Deficient/Hyperactivity Disorder

Other: _____

Jaffe Ethical Addiction and Pain Care , LLC

Opioid/Buprenorphine Patient Prescriber Agreement

This Patient Prescriber Agreement (PPA) is designed to:

1) Create an open conversation between the patient and the prescriber about the risks, benefits, and limitations of these medications for the treatment of pain;
2) Be used as a decision making tool before an opioid medication is used for acute or chronic pain;
3) Ensure the appropriate, safe and legally compliant usage of opiate medications.

Part 1: For the Patient; Will Opiates Help My Pain?

Check off each area after discussing with your physician/prescriber.

1)__Pain is different in each individual. Opiates do not “treat” pain, they alter your perception of pain in the “lateral (dopamine) pathways”. Newer studies show “Around the Clock” usage should be reserved for cancer related pain only. Frequency and dosage (usually no more than three times a day) is determined by response to initiation of the medication. The benefits should outweigh the side effects of continuing to use the medications.

2)__I hope opioid medicines will reduce my pain, making it easier to:

___Return to work _

___Improve my sleep

___Climb stairs

___Walk short/longer distances

___Do daily chores.

3) I agree to participate by trying to:

___Start a light/moderate exercise program

___Lose weight and Eat a Pain Diet

___Stop smoking or other negative habits.

Opioid/Buprenorphine PPA

1)___My prescriber and I may also try alternative or additional

Treatments for my condition, including;

___Non-opioid medications, over the counter as well as prescription medications;

___Physical Therapy, Exercise and Massage Therapy, Acupuncture;

___Self Management Techniques and Coping Strategies such as

Meditation, Stress Reduction, Counseling, Coaching and Support Groups, and attention to good sleep habits;

___Discussion of Surgical or Interventional Pain Procedures.

2)___I will be made aware of opioid medications side effects:

__a) Dependence- Within days the body can become physically dependent with withdrawal symptoms such as; runny nose, chills, aches, diarrhea, sweating, nausea and vomiting and insomnia. This can be lessened with the drug Suboxone, which also treats pain. Physical Dependence and Tolerance require medically supervised weaning.

___b) Tolerance- Defined as needing more drug to get the same amount or less pain relief than previously. This is an indication of a need to detoxify from the medication just as if dependent.

___c) Addiction- Defined as continuing to use a medication despite negative consequences. This includes using in a fashion other than as prescribed (injecting instead of orally), or obtaining from an illicit source, exaggerating your pain to get more drug, or not reporting negative side effects. My prescriber will help me to reduce and detoxify from the medication, and obtain alternate ways to control my pain.

3)___Table 1- **Opioid Side Effects:** The table below lists common and potential opioid side effects and the percentage of occurrence.

Opioid Side Effect	Frequency/Incidence
Addiction Potential	Up to 30% or higher
Sleep Apnea, Insomnia	25-75%
Confusion/Memory Problems	Varies from Study to Study
Constipation	30-40%
Depression (New or Pre-existing)	Most studies report about 30%-40%
Drowsiness	15-20%, may lessen over time
Dry Mouth/Dental Caries/Loss of Teeth	Up to 50%, suggested to carry an alcohol free Fluoride mouthwash and use often
Intestinal Blockage	Fortunately <1-2% per year
Itching	Depends on opiate, may go away
Lowered Testosterone and Other Hormones, Infertility and Impotence	25-75%, may respond to hormone replacement therapy
Nausea or Vomiting	0-50%
Overdose Leading to death	<1% Per Year (Used as Directed) Higher with Methadone
Dependence	65-95% after 5 days
Tolerance	Believed to be <40%
Unexpected Increase in Pain	Believed to be <15%

Opioid/Buprenorphine PPA

4)___Opioid medication WILL impair my judgement and response time. I understand that while on these medications I am cautioned not to drive, operate machinery, or sign important documents. I understand that people do, and if I choose to do so, I do so at my own risk.

5)___Taking even small amounts of alcohol, or sleeping pills, anti-histamines, or anti-anxiety medications while on opiate medications can increase the chances of side effects, especially accidental overdose.

6)___Routine and random pill counts, calls for office visits for an evaluation for possible misuse or mixing of medications is a part of opiate medication management. I agree to provide a sample if requested of urine, blood or saliva.

7)___I agree to discuss with my prescriber past history of myself and my family, especially past and present use of any habit forming substances before we try to treat my condition with an opiate medicine. This includes the use of tobacco and alcohol.

8)__Having discussed the above issues and information, a decision about using opioid medicine was reached.

____Yes, we have agreed to try an opioid for my condition. We will proceed with the discussion below.

____No, we will not use opiates and therefore will not continue With the discussion.

PART 2: FOR THE PATIENT: My Promise to use Opioids Safely

Now that my prescriber and I have agreed that I will try an opioid medicine, I understand that I need to take an active role in my own health care to get the most benefit and reduce the chance of side effects from using an opioid medicine. My prescriber wants me to have the following information so that I may have the best possible pain reduction while also protecting my health and reducing the chances of possible harm to myself and others while I am taking an opioid medicine.

1)____ I told my prescriber about all the medicines I am taking, including any prescription, over-the-counter and herbal medicines. I will also discuss with my prescriber any new medicine that I take in the future. Some medicines and other substances, such as alcohol, sleeping medicines, antihistamines and anti-anxiety medicines can increase the chance of accidental overdose. If I use these medicines along with an opioid medicine, they can cause death! My prescriber will provide Narcan for home use. It is my responsibility to be sure this is provided and stays current.

2)____ If I start to have more pain or other unusual or severe side effects, I will contact my prescriber right away. We may need to change the dose or try a different opioid medicine. I will not make any changes to the opioid medicine without first talking to my prescriber. This is a felony! It may also indicate a need for a break from the medication.

3)____ I will tell my prescriber if I am pregnant or planning to become pregnant. Taking opioid medicine during pregnancy will harm my unborn baby.

4)____ I will not share this opioid medicine with other people. My prescriber and I have selected this opioid medicine for me, and it is only for me. It is against the law to share an opioid medicine with other people. Sharing an opioid medicine with another person can cause serious harm to them, including death, and it is a felony for both the other person and me.

5)____ I will keep my opioid medicine in a secure place where other people, especially children, cannot reach it. If someone accidentally takes some of my opioid medicine or I accidentally take too many doses, I will contact my prescriber or call the **Poison Control Center** at **1-800-222-1222**. Adult prescriptions are the first drug most children take.

6)____ I will remove expired, unwanted or unused opioid medicine from my home to avoid accidentally harming children, other adults, or myself.

7)_____I may be able to drop off unused opioid medicine through a "medicine take-back program". A "medicine take-back program" is an official place and time for dropping off unused opioid and other medicines.

8)_____If I cannot find a "medicine take-back program" or if I want to remove the medicine from my home right away, I can flush my opioid medicine down the toilet.

9)____My opioid medicine can also be mixed with cat litter or coffee grounds and thrown out with the household trash.

Part 3: For the patient and the prescriber.

1)_____My prescriber and I have discussed all the items on this checklist.

2)_____We both agree that an opioid pain medicine is the best choice for my condition at this time.

3)_____My prescriber and I agree that we will go over this checklist again in the future.

Patient Name_____

Date_____/_____/_____

Patient signature_____