Please fill out the first page using colored pencils.
All other pages should be written in ink.

NAME: _____

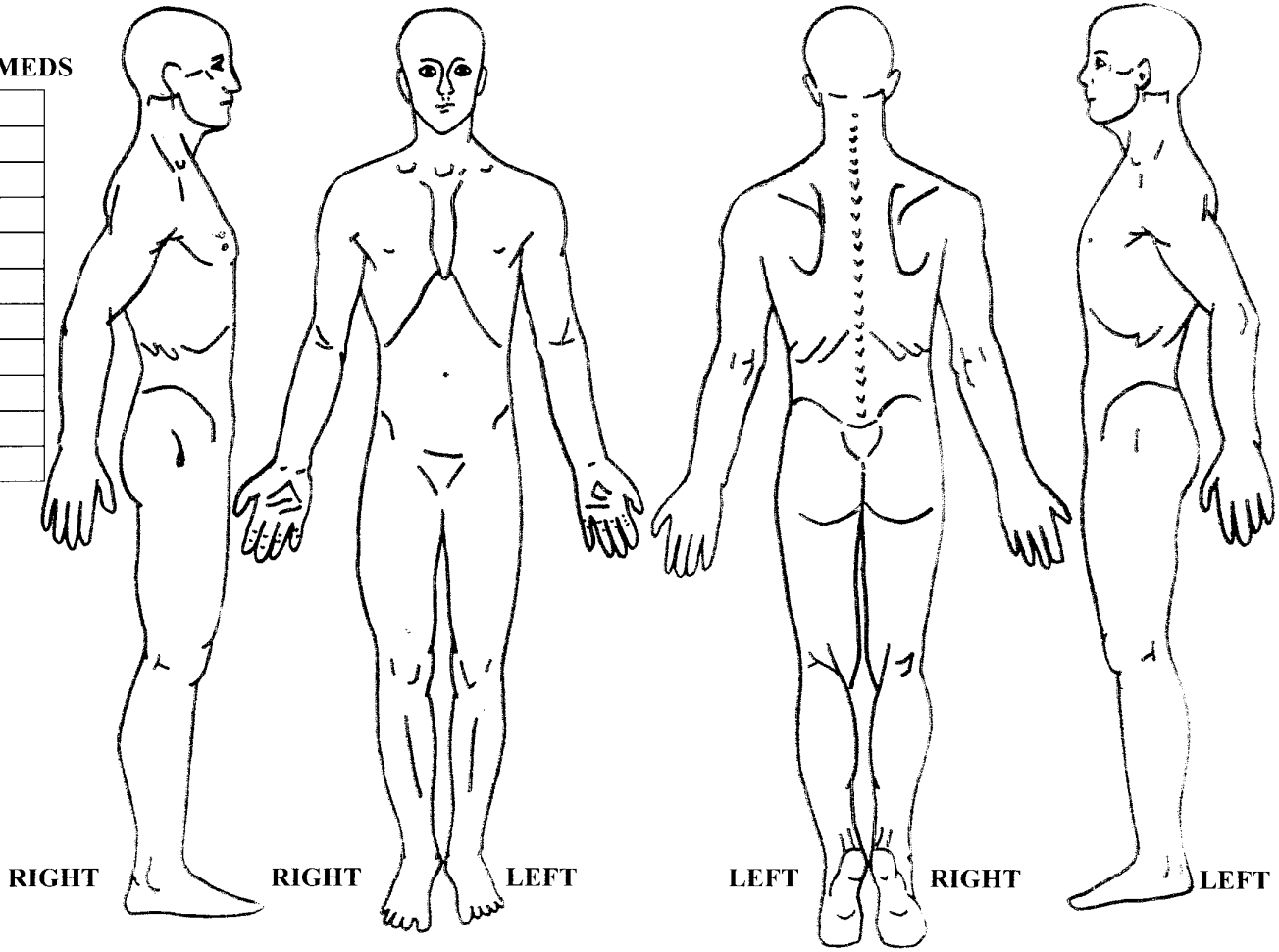
DATE: _____

AZUL=DOLOR BLUE=PAIN	AMARILLO=ENTUMECIMIENTO/CORRIENTE YELLOW=NUMBNESS OR TINGLING	ROJO=ARDIENDO RED=BURNING	VERDE=CALAMBRE GREEN=CRAMPING

INSTRUCTIONS:
USE THE COLORS LISTED ABOVE TO SHADE THE AREAS ON YOUR BODY THAT HAVE PAIN, NUMBNESS, TINGLING, BURNING, OR CRAMPING

PATIENT INFORMATION RECORD

	RATE YOUR PAIN 0 – 10	
WITH MEDS		WITHOUT MEDS
	HEADACHE	
	JAW PAIN	
	NECK SYMPTOMS	
	SHOULDER SYMPTOMS	
	MIDDLE BACK	
	LOWER BACK SYMPTOMS	
	ARM SYMPTOMS	
	ARM NUMBNESS	
	FINGER NUMBNESS	
	LEG SYMPTOMS	
	FOOT SYMPTOMS	



Patient Comfort Assessment Guide

Name: _____ Date: _____

1. Where is your pain? _____

2. Circle the words that describe your pain.

aching	sharp	penetrating
throbbing	tender	nagging
shooting	burning	numb
stabbing	exhausting	miserable
gnawing	tiring	unbearable

Circle One occasional continuous

What time of day is your pain the worst? Circle one.

morning afternoon evening nighttime

3. Rate your pain by circling the number that best describes your pain at its worst in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

4. Rate your pain by circling the number that best describes your pain at its least in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

5. Rate your pain by circling the number that best describes your pain on average in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

6. Rate your pain by circling the number that best describes your pain right now.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

7. What makes your pain better? _____

8. What makes your pain worse? _____

9. What treatments or medicines are you receiving for your pain? Circle the number to describe the amount of relief the treatment or medicine provide(s) you.

a) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

b) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

c) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

d) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

10. What side effects or symptoms are you having? Circle the number that best describes your experience during the past week.

a. Nausea	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
b. Vomiting	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
c. Constipation	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
d. Lack of Appetite	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
e. Tired	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
f. Itching	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
g. Nightmares	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
h. Sweating	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
i. Difficulty Thinking	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
j. Insomnia	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine

11. Circle the one number that describes how during the past week pain has interfered with your:

a. General Activity	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
b. Mood	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
c. Normal Work	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
d. Sleep	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
e. Enjoyment of Life	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
f. Ability to Concentrate	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
g. Relations with Other People	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes

Prepared by Elizabeth J. Narcessian, M.D., Clinical Chief of Pain Management, Kessler Institute for Rehabilitation, Inc.

B5375 00MC59 6/01

Please print clearly **using a pen**. If something does not apply to you, mark "n/a" in the appropriate space.

PERSONAL INFORMATION

Today's Date: _____
Legal Name: _____
Date Of Birth: _____ Age: _____ Sex: _____
Social Security Number: _____-_____-_____
Street Address: _____
_____
City: _____ State: ____ Zip: _____
Home Telephone: (_____) _____
Work Telephone: (_____) _____
Mobile Telephone: (_____) _____
Which is the Best Number at Which to Reach You? ☐ Home ☐ Cell ☐ Work
Email: _____
Employer (If Employed) _____
Employer Address: _____
_____
Please Give the Name of an Emergency Contact Not Living with You:
_____ Relationship: _____
Home Phone: (_____) _____ Work Phone: (_____) _____ Mobile Phone: (_____) _____

SPOUSE'S INFORMATION (IF MARRIED)

Name: _____
Social Security Number: _____
Date Of Birth: _____
Employer (If Employed): _____
Work Telephone: (_____) _____
Mobile Telephone: (_____) _____

MEDICAL INFORMATION

Please List All Allergies _____
_____
Height: _____ Weight: _____lbs.
Date of Accident OR Onset of Illness: _____
If Accident, Is it Work Related? ☐Yes ☐ No How Did Accident Happen? _____
_____
_____
_____

(CONTINUED ON PAGE 2)

DOCTOR, ATTORNEY, AND REFERRAL INFORMATION

Who Referred You To This Office? _____ Phone: (_____)_____
Are You Being Treated For This Condition By Another Physician? ☐Yes ☐ No:
If Yes, Name of Doctor: _____ Phone: (_____) _____
Do You Have An Attorney for this Condition? ☐Yes ☐ No
If Yes, Name Of Attorney: _____
Street Address: _____
_____
City: _____, State: _____ Zip: _____
Telephone Number: (_____) _____ Fax: (_____) _____

AUTO INSURANCE (ONLY IF YOUR VISIT IS RELATED TO AN AUTO ACCIDENT)

Insurance Company Name: _____
Name Of Insured (If Not Yourself): _____
Policy #: _____ Claim #_____ Adjuster's Name: _____
Claims Address: _____
_____
Telephone Number: (_____) _____ Fax: (_____) _____

HEALTH INSURANCE INFORMATION

Insurance Company Name:_____
Name Of Insured (If Not Yourself): _____ Relationship: _____
ID#: _____ Group Number (If Applicable):_____
Claims Address: _____
_____
Telephone Number: (_____) _____ Fax: (_____) _____

SECONDARY OR SUPPLEMENTAL HEALTH INSURANCE INFORMATION

Insurance Company Name:_____
Name Of Insured (If Not Yourself): _____ Relationship: _____
ID#: _____ Group Number (If Applicable):_____
Claims Address: _____
_____
Telephone Number: (_____) _____ Fax: (_____) _____

PLEASE COMPLETE THIS SECTION IF PATIENT IS A MINOR (UNDER 18 YEARS OF AGE)

Your Relationship to Patient:: ☐ Mother ☐ Father ☐ Legal Guardian
Your Name: _____Social Security Number: _____ Date Of Birth: _____
Street Address: _____
City: _____, State: _____ Zip: _____

*****Please Use Ink*****

AUTHORIZATION TO RELEASE RECORDS

I hereby authorize the disclosure of my protected health information and medical information **(PHI/MI)** (or that of an un-emancipated minor child for whom I have legal authority) as described below. **I understand that this authorization is voluntary**. I understand that any information released may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State Law.

THIS AUTHORIZATION IS FOR THE RELEASE OF PHI/MI FOR:

Name: _____ Date of Birth: _____

Release Information From:

_____
_____
_____
_____

Release Information To:

Paul H. Wand, MD
Brain Healing Center of America, PA
2855 N. University Dr. #210
Coral Springs, FL 33065
954-344-9772 fax-954-344-9760

Description of information (choose one):

☐ All records from the date of my first visit until this authorization is revoked.

☐ Other (state type of records and date range): _____
_____

Please initial the following statements:

I understand that:

1. I may revoke this authorization at any time with written notification. If I do revoke, I understand that this will have no effect on records releases made prior to receiving the revocation. Initial: _____

2. My health care and payment for my health care will not be denied if I do not sign this form. Initial: _____

3. This authorization expires on: _____ (you may enter 12/31/09 if you choose) or upon the occurrence of _____ (event). Initial: _____

4. There may be a charge for copying records. Initial: _____

5 I will receive a copy of this form after I sign it. Initial: _____

Signature: _____ Today's Date: _____

Relation to Patient (If not self): _____

CANCELLATION & NO-SHOW POLICY

Cancellation of a scheduled appointment for an office visit **MUST BE MADE 24 HOURS** in advance to avoid the cancellation fee of **$50.00**. No-show appointments will also be charged **$50.00**.

I hereby authorize Paul H. Wand, MD/ Brain Healing Center of America, PA to bill me for missed appointments.

Name: _____

Signature: _____

Date: _____

Paul H. Wand, MD
Brain Healing Center of America, PA
2855 N. University Drive Ste. 210 Coral Springs, FL 33065
Tel: (954) 344-9772 Fax: (954) 344-9760

This is your copy. Please take it with you. It is not necessary to return it to the receptionist.

NOTICE OF PRIVACY PRACTICES AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCES TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE READ THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable 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 maintain the confidentially of health information that identifies you. 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 you 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.
- Your privacy rights in your PHI.
- Our obligations concerning the use and disclosure of 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 has created or maintained 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 offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Paul Wand, M.D. at 2855 N. University Dr., Coral Springs, FL, 33065

C. WE MAY USE AND DISCLOSE YOUR INDIVIDYALLY IDENTIFIABLE HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

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

1. Treatment. The information in your medical records will be used to determine which treatment option best addresses your health needs. The treatment selected will be documented in your medical records so that other health care professional can make informed decisions about your care. For example, we may ask you to have laboratory tests, and we may use the results to help us reach a diagnosis. Many of the people who work for our practice- including, but not limited to, our doctors and staff – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice 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 rage 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 family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. As examples 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, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointments and Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment or as a follow up on treatment.

5. Non-Medical Communications. Our practice may use your PHI to contact you for non-medical reasons. For example, we may send you a birthday card or a holiday greeting via mail.

6. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives. We may treat you in an open treatment area and some incidental PHI may be overheard by other patients being treated at the same time.

7. Health-Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health-relates benefits or services that may be of interest to you. For example, we may send you newsletters that may include information about our practice, health related issues and products and services.

8. Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

9. 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.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risk. Our practice may disclose your PHI to public health authorities that are authorizes by law to collect information for the purpose of:

A. Maintaining vital records, such as births and deaths;
B. Reporting child abuse or neglect;
C. Preventing or controlling disease, injury or disability;
D. Notifying a person regarding potential exposure to a communicable disease;
E. Notifying a person regarding a potential risk for spreading or contracting a disease or condition;
F. Reporting reactions to drugs or problems with products or devices;
G. Notifying individuals if a product or device they my be using has been recalled;
H. 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 id the patient agrees or we are required or authorized by law to disclose this information; and
I. Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. 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; other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also my disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but 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.

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

A. Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement;

B. Concerning a death we believe has resulted from criminal conduct;

C. Regarding criminal conduct at our offices;

D. In response to a warrant, summons, court order, subpoena or similar legal process;

E. To identity/locate a suspect, material witness, fugitive or missing person; and

F. In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator).

5. Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health of Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the 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.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. 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.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are and inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following regarding the PHI that we maintain about you:

1. 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 instance, you may ask the we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Paul Wand, M.D.,** our privacy Officer, at **2855 N. University Dr., Coral Springs, FL, 33065,** specifying the requested method or 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.

2. 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 to only certain individuals involved in your care or the payment for your care, such as family members and friends, 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 **Paul Wand, M.D.,** our Privacy Officer, at **2855 N. University Dr., Coral Springs, FL, 33065.** Your request must describe in a clear and concise fashion:

A. the information you wish restricted;

B. whether you are requesting to limit our practice's use, disclosure or both; and

C. to whom you want the limits to apply.

3. Inspection and 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 and billing records, but not including psychotherapy notes. You must submit your request in writing to **Paul Wand, M.D.,** our Privacy Officer, at **2855 N. University Dr., Coral Springs, FL, 33065,** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of or denial, another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us 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 an amendment, your request must be made in writing and submitted to **Paul Wand, M.D.,** our Privacy Officer, at **2855 N. University Dr., Coral Springs, FL, 33065.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. 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 kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless thee individual or entity that created the information in not available to amend the information.

5. 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 non-routine disclosures our practice has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice in not required to be documented. For example, the doctor is sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Paul Wand, M.D.,** our privacy Officer, at **2855 N. University Dr., Coral Springs, FL, 33065.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 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.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Paul Wand, M.D.,** our Privacy Officer, at **2855 N. University Dr., Coral Springs, FL, 33065.** Right to a file a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Paul Wand, M.D.,** our Privacy Officer, at **2855 N. University Dr., Coral Springs, FL, 33065.** All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. 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 authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Paul Wand, M.D.,** our Privacy Officer, at **2855 N. University Dr., Coral Springs, FL, 33065**

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

PAUL H. WAND, MD
Brain Healing Center of America, PA
2855 N. University Drive, Ste 210
Coral Springs, FL 33065
Tel: (954)344-9772
Fax: (954)344-9760

I, _____, have received a copy of
(Print Patient Name)

Paul H. Wand, MD/ Brain Healing Center of America, PA, Notice of Patient Privacy Practices.

_____
(Signature of Patient or Parent or Legal Guardian)

Date: _____

Because you are visiting our office for pain management, you may be prescribed medications from a class known as opiates. Please read the following agreement and then, BEFORE SIGNING IT, bring it to the receptionist so that you can sign it IN HER PRESENCE. Thank you.

INFORMED CONSENT AGREEMENT
LONG TERM OPIATE THERAPY FOR TREATMENT OF NON-MALIGNANT PAIN

You have agreed to a trial of opiate therapy for the treatment for chronic non-malignant (non-cancer) pain. The purpose of this treatment is to reduce your pain and to improve your level of function at work, at home and/or in other valued activities.

Alternative therapies have been explained and offered to you. You have elected a trial of opiate therapy as one component of treatment

It is important that you be aware of the potential risks and side effects of these medications. Common issues are discussed below.

PHYSICIAL SIDE-EFFECTS

Common side effects include mood changes, drowsiness, constipation, nausea and/or confusion. Many of these side effects gradually resolve over days to weeks. Constipation often persists and may require management with medications. If other side effects persist, trial of alternative opiates may be necessary or opiates may need to be discontinued. You should not drive a car or other vehicles or operate machinery if the medication makes you drowsy. The sedative effects of alcohol and other sedatives are additive with the side effects of opiates. It is strongly advised that you avoid alcohol while receiving opiate therapy. If you take more medication than prescribed, a dangerous situation could result, such as coma, organ damage or even death.

PHYSICAL DEPENDENCE

Physical dependence is an expected side effect of the long term use of opiates if they are prescribed on an around-the-clock basis. This means that if you take opiates continuously and stop them abruptly for any reason, you will experience a withdrawal symptom. This symptom often includes sweating, diarrhea, sleeplessness, runny nose, tearing, muscle and bone aching and dilated pupils. To prevent these symptoms, medications must be taken regularly if physical dependence is present. When opiates are discontinued, they should be tapered under the supervision of your physician.

TOLERANCE TO THE MEDICATION

Tolerance to the pain killing properties of opiate medication is possible with continuous use. This means that increasing medications is required to achieve the same level of pain control experienced when the medications were initiated, although there has been no physical change in the underlying condition. We do not fully understand why, or understand under what conditions tolerance to the pain-killing effects of opiates occur. When it does occur during opiate therapy of chronic non-malignant pain, however, it sometimes requires tapering and discontinuation of the medication. Sometimes tolerance can be handled by substituting another opiate medication.

When initiated, doses of medication must be adjusted to achieve authentic effect; upward adjustments in this period are not viewed as tolerance.

INCREASED PAIN

The long-term effects of opiates on the body's own pain-fighting systems are unknown. Some evidence suggests that they may interfere with pain modulation, resulting in increased sensitivity to pain. Sometimes individuals who have been on long-term opiates, but who continue to have pain, actually note decreased pain after several weeks off of the medications. Some clinicians believe opiates reinforce or perpetuate the perception of pain.

ADDICTION

Addiction is present when an individual experiences loss of control over the use of medication, is constantly seeking drugs and/or experiences adverse consequences as a result of drug use. Most pain patients who use opiates for the treatment of pain are able to take medications on a scheduled basis as prescribed, do not seek other drugs when their pain is controlled and experience improvement in the quality of life as a result the medications; thus, they are not addicted. Physical dependence does not indicate addiction.

RISK TO UNBORN CHILDREN

Children born to some women who are taking opiates on a regular basis likely will be physically dependent at birth. Women of childbearing age should maintain safe and effective birth control while on opiate therapy. Should you become pregnant, immediately contact your physician and the medication will be tapered and stopped.

PRESCRIPTION AND USE OF MEDICATION

Your medication will be prescribed on an around-the clock basis for continuous pain control. You will be provided enough medication on a monthly basis with a limited amount of additional medication when needed for breakthrough pain. New injuries or pain problem will require re-evaluation.

PATIENT AGREEMENT

You will agree to fill opiate prescriptions at one pharmacy. This pharmacy is: _____.

- Lost, stolen or destroyed prescriptions will not be replaced and may result in discontinuation of treatment.
- You agree to obtain opiate medications from only one prescribing physician, Paul Wand, M.D., or if he is not available, his designated substitute.
- You agree to be evaluated initially on a monthly basis and thereafter, as your physician believes is necessary.
- You agree to necessary blood and urine testing to monitor levels of medications and any organ side effects.

Opiate therapy will be continued if you experience:

1) Decreased pain
2) Improvement in your function at work, at home and/or in other valued situations.

Opiate therapy will be discontinued if you:

1) Develop progressive tolerance, which cannot be managed by changing medications.
2) Experience unacceptable side effects which cannot be controlled.
3) Experience diminishing function or poor pain control.
4) Develop signs of addictive medication use or abuse of other drugs.
5) Increase your medication without communicating with the doctor.
6) Obtain opiates from multiple physicians or from street sources.
7) Fill prescriptions at other pharmacies without explanation.
8) Sell, give away or lose medications.

I have had the opportunity to review this Informed Consent Agreement for long term opiate therapy for the treatment of non-malignant pain. I have been given the opportunity to ask questions about the proposed treatment, potential risks and benefits. I accept the risks and conditions of the proposed treatment as presented.

_____ ____/____/____
(Patient signature) **Date**

_____ ____/____/____
(Signature of person obtaining Consent Agreement) **Date**

_____ ____/____/____
(Witness) **Date**

Paul H Wand, M.D.

Thank you for completing this paperwork! Please bring it to the receptionist, along with your driver's license and insurance card.

(We need the insurance card even if we do not participate with your plan, because it may be needed to file claims for testing ordered later. Also, even though you will be paying us directly, we will be happy to submit a claim which may provide you with some reimbursement.)

Thank you!