ALBEMARLE
PAIN MANAGEMENT ASSOCIATES

New Patient Registration Paperwork
Pain Management Associates
600 Peter Jefferson Parkway, Suite 170
Charlottesville, VA 22911

Patient Registration – 2015

Patient Name: _____ Date of Initial Visit: _____

DOB: _____ SSN: _____ Sex: ☐Male ☐ Female

Name of person completing this form (if different from patient): _____

If patient is a minor, list Guardian's name: _____

Mailing Address: _____

Physical Address (if different): _____

Race ☐Asian ☐Native Hawaiian ☐Other Pacific Islander ☐Black/African American

☐American Indian/Alaskan Native ☐White ☐More than One Race ☐Unreported/ Refuse to Report

Ethnicity ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Unreported/Refuse to Report

Language ☐English ☐Spanish ☐French ☐Other_____

Phone Number: (H) _____ (W) _____ (C) _____

Emergency Contact Name: _____

Relationship to Patient: _____ Phone Number: _____

Address: _____

Primary Care Physician Name:_____

Address:_____ Phone:_____

Referring Physician Name:_____

Address:_____ Phone:_____

Please list any other specialists you see:

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

How did you hear about us? *(please check all that apply)*

☐ Word of Mouth ☐ Website ☐ Physical Therapist ☐ Primary Care Physician ☐ Other: _____

FINANCIAL RESPONSIBILITY

Person Financially Responsible for this Account: _____
DOB: _____ SSN: _____
Address: _____
Phone Number: (H) _____ (W) _____ (C) _____
Employer: _____
Employer Address: _____
Employer Phone: _____ Position: _____

INSURANCE INFORMATION

Is this visit related to a specific **Motor Vehicle Accident**? ☐ Yes ☐ No Date of Accident: _____

State Accident Occurred: _____

Is this visit related to **Workers' Comp**? ☐ Yes ☐ No Date of Injury: _____

Employer: _____

Primary Insurance Company Name:		**Secondary** Insurance Company Name:	
Policy Holder's Name :	DOB:	Policy Holder's Name:	DOB:
Policy Holder's Employer:	Policy Holder's SSN:	Policy Holder's Employer:	Policy Holder's SSN:
Policy #:	Group #:	Policy #:	Group #:
Address:		Address:	
City, State & Zip:		City, State & Zip:	
Telephone #:		Telephone #:	
Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Parent ☐Other		Relationship to Patient (circle one): ☐Self ☐Spouse ☐Child ☐Parent ☐Other	

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

- I certify that the information I have provided with regards to my insurance coverage is correct.
- I authorize the use of this form and any information provided on this form on all insurance submissions.
- I authorize release of medical information to the insurance companies listed above.
- I understand that I am personally responsible for my bill in the event of non-coverage by insurance.
- I authorize Dr. Dean and staff to act as my agent in helping me to obtain payment from the insurance companies listed above.
- I authorize payments from the insurance companies listed above to be made directly to Dr. Dean and/or Osteopathic Physicians of Charlottesville, DBA Pain Management Associates.
- Should my account become delinquent in excess of 90 days, I understand that I may be asked to pay all costs of collection, including but not limited to the agency fees, and to pay interest at the rate of 18% per annum from and after the date of treatment and to pay any necessary and reasonable attorney fees incurred in the collection of my account, whether or not a suit is filed.

Responsible Party's Signature: _____ Date: _____

Print Name: _____ Initial _____

Clinical Information

Chief Complaint: _____

Where is your Pain? ☐Head ☐Neck ☐Upper Back ☐Lower Back ☐Chest

☐Arm(s) ☐Leg(s) ☐ Other: _____

Use the pain scale described below to rate your pain for the questions below:

0 – Pain Free

1 - Very Minor annoyance, occasional minor twinge

2 - Minor Annoyance, occasional strong twinges

3 - Annoying enough to be distracting

4 - Can be ignored if you are really involved in your work/task, but still distracting

5 – Cannot be ignored for more than 30 minutes

6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities

7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort

8 – Physical activity is severely limited. You read and talk with effort. You may have Nausea and dizziness caused by pain

9 – Unable to speak, crying out or moaning uncontrollably

10 –Unconscious, pain makes you pass out or feel as though you might pass out.

___What number on the pain scale (0-10) best describes your pain right now?

___What number on the pain scale (0-10) best describes your worst pain?

___What number on the pain scale (0-10) best describes your least pain?

___What number on the pain scale (1-10) best describes your average pain over the last month?

Onset of Symptoms: _____

Approximately when did this pain begin? _____

What caused your current pain episode? _____

How did you current pain begin? ☐ Gradually ☐ Suddenly

Since your pain began how has it changed? ☐ Decreased ☐ Increased ☐Stayed the same

Pain Description: _____

☐ Aching ☐ Numbness ☐ Spasming ☐ Throbbing ☐ Hot / Burning

☐ Cramping ☐ Shock-Like ☐ Squeezing ☐ Tingling / Pins & Needles

☐ Dull ☐ Shooting ☐ Stabbing/ Sharpe ☐ Tiring/ Exhausting

Pain Frequency:_____

What word best describes the frequency of your pain? ☐ Constant ☐ Intermittent

When is your pain the worst? ☐Mornings ☐During the day ☐Evenings ☐Night

Mark all the activities that are adversely / negatively affected by your pain

☐Enjoyment of Life ☐Normal Work ☐Sleep

☐General Activity ☐Recreational Activities ☐Walking

☐Mood ☐Relationship with People

In the past three months have you developed any new?

☐Balance Problems ☐Bladder Incontinence ☐Bowel Incontinence ☐Chill

☐Difficulty Walking ☐Fevers ☐Nausea ☐Vomiting

☐Numbness/Tingling – Where:_____ ☐Weakness – Where:_____

☐**I have not recently developed any of the above conditions**

Diagnostic Tests and Imaging:_____

Mark all of the following ures you have had that are related to your current pain complaints:

☐ MRI _____ ☐ < 6 months ☐ >6 months Facility:_____

☐ X-ray _____ ☐ < 6 months ☐ >6 months Facility:_____

☐ CT Scan _____ ☐ < 6 months ☐ >6 months Facility:_____

☐ EMG/NCV study _____ ☐ < 6 months ☐ >6 months Facility:_____

☐ Ultrasound _____ ☐ < 6 months ☐ >6 months Facility:_____

☐ Other Diagnostic Testing:_____

☐ **I have not had any diagnostic tests performed for my current pain complaints**

Pain Treatment History:

Mark all of the following pain treatments you have undergone prior to today's visit:

☐ Chiropractic ☐ Physical Therapy ☐ Psychological therapy ☐ Podiatrist Tx

☐ Discogram (Check all levels that apply) ☐ Cervical ☐ Thoracic ☐ Lumbar

☐ Epidural Steroid Injection (Check all Levels that apply) ☐Cervical ☐ Thoracic ☐ Lumbar

☐ Joint Injection – Joint(s)_____

☐ Medial Branch Block or Facet Injections (Check all levels that apply)

☐Cervical ☐ Thoracic ☐ Lumbar

☐ Nerve Block – Area/ Nerve(s)_____

☐ Radio Frequency Ablation: (Check all levels that apply) ☐ Cervical ☐ Thoracic ☐ Lumbar

☐ Spinal Cord Stimulator – (check one) ☐ Trial Only ☐ Permananet Implant

☐ Trigger Point Injection – Where?_____

☐ Vertebroplasty / Kyphoplasty Where?_____

☐ Other: _____

☐ **I have not had any prior treatments for my current pain complaints**

Family History (check the following that apply)

Family History:

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures	Stroke
Mother													
Father													

Other medical Problems:_____

Mother: ☐ Alive ☐ Deceased Age:____

Father: ☐ Alive ☐ Deceased Age:____

Children: ☐ Yes ☐ No Medical Conditions: ☐ Yes _____ ☐ No

Ages:_____

☐ **I have no significant family medical history** ☐ **I am adopted (No medical history available)**

Past Surgical History:

Please list any surgical procedures you have had done in the past including the date, type and any pertanent details.

Abdominal Surgery:

☐ Gall Ballader Removed _____

☐ Appendectom: _____

☐ Other_____

Female Surgeries:

☐ Caesaren Section: _____

☐ Hysterectomy: _____

☐ Laparoscopy: _____

☐ Ovarian: _____

☐ Other:_____

Heart Surgery:

☐ Valve replacement: _____

☐ Aneurysm Repair: _____

☐ Stent placement: _____

☐ Other: _____

Joint Surgery:

☐ Shoulder: _____

☐ Hip: _____

☐ Knee: _____

Spine / Back Surgery:

☐ Discectomy:_____

☐ Laminectomy:_____

☐ Spinal Fusion: _____

Other Common Surgeries:

☐ Hemorrhoid Surgery

☐ Hernia repair: _____

☐ Thyroidectomy: _____

☐ Tonsillectomy: _____

☐ Vascular Surgery: _____

Please list any other surgeries and dates (attach additional sheet if necessary):

_____

_____

_____

☐ **I have never had any surgical procedures done.**

Medication Information

Allergies: Do you have any known medication allergies?

If so please list all medications you are allergic to and the reaction you have if known

Medication Name:	**Allergic Reaction:**
1.	
2.	
3.	
4.	
5.	

Please check if your are allergic to" ☐ Iodine ☐ Tape ☐ Shellfish

Are you allergic to Latex? ☐ Yes ☐ No

Please list all medications you are currently on with the dose and frequency and who is currently prescribing it for you:

Current Medication	**Dose**	**Frequency**	**Prescriber**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Please add Additional Medications on a separate sheet and attach to this form.

Please indicate which (if any) of the following blood thinners you are taking:

☐ Aggrenox ☐ Coumadin / Warafin ☐ Effient ☐ Lovenox ☐ Plavix ☐ Pletal ☐ Pradaxa

☐ Ticlid ☐ Xarelto ☐ Other: _____

☐ **I am not currently on any medications**

Prescription Pain Medication Usage

Please indicate which medications you have used in the past for **your current pain condition**. (If none leave blank – this is for your current pain condition only)

Anti-Inflammatory	**Helped**
☐ Naproxen (aleve)	☐Yes ☐ No
☐ Ibuprofen (advil, motrin)	☐Yes ☐ No
☐ Diclofenac (voltaren)	☐Yes ☐ No
☐ Tylenol (Acetaminophen)	☐Yes ☐ No
☐ Celebrex	☐Yes ☐ No
☐ Flector Patch	☐Yes ☐ No

Muscle Relaxants	**Helped**
☐Carisoprodol	☐Yes ☐ No
☐ Cyclobenzaprine (Flexeril)	☐Yes ☐ No
☐ Skelaxin (Metaxolone)	☐Yes ☐ No
☐ Methocarbamol (Robaxin)	☐Yes ☐ No
☐ Tizanidine (Zanaflex)	☐Yes ☐ No

Nerve Medications	**Helped**
☐ Gabapentin (Neurontin)	☐Yes ☐ No
☐ Lyrica	☐Yes ☐ No
☐ Amitriptyline (Elavil)	☐Yes ☐ No
☐ Nortriptyline	☐Yes ☐ No
☐ Cymbalta	☐Yes ☐ No
☐ Effexor	☐Yes ☐ No
☐ Savella	☐Yes ☐ No
☐ Lidoderm patch	☐Yes ☐ No

Narcotic / Opioids	**Helped**
☐Hydrocodone (Vicodin)	☐Yes ☐ No
☐Tylenol with Codeine	☐Yes ☐ No
☐Oxycodone (Percocet)	☐Yes ☐ No
☐Morphie, MS Contin	☐Yes ☐ No
☐Hydromorphone (Dilaudid)	☐Yes ☐ No
☐Tramadol	☐Yes ☐ No
☐ Nucynta (Tapentadol)	☐Yes ☐ No
☐ Fentanyl Patch (Duragesic)	☐Yes ☐ No
☐ Methadone	☐Yes ☐ No
☐ Opana	☐Yes ☐ No
☐ Opana ER	☐Yes ☐ No
☐ Avinza	☐Yes ☐ No
☐ Suboxone	☐Yes ☐ No
☐ Butrans Patch	☐Yes ☐ No

Have you ever been addicted to or misused prescription drugs? ☐ Yes ☐ No

Type:_____

Social History:_____

Occupation:_____ When was the last time you worked?_____

☐Restricted or Light Duty ☐Temporary Disability ☐Permanent Disability ☐Retired

☐Unemployed/Seeking Job

Are you currently under workers compensation? ☐ Yes ☐ No

Is there an ongoing lawsuit related to your visit today? ☐ Yes ☐ No

Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Widowed

Is anyone at your home to assist you as needed with daily activities of Living?

☐Yes Who:_____ ☐ NO

Are you capable of getting pregnant? ☐Yes ☐No If so are you currently pregnant ☐ Yes ☐ No

Highest level of education obtained: ☐Grade School ☐High School ☐College

Alcohol Use: ☐ Current Daily Alcohol use: Amount:_____

☐ Social Alcohol use: Amount:_____ Frequency:_____

☐ History of alcoholism

☐ Never Drinks alcohol

Tobacco Use: ☐ Current Tobacco Use

☐Cigarettes (Packs/Day) ___ ☐ Cigars_____☐ Snuff_____

☐ Former Tobacco Use Year Quit: _____

☐ Never use Tobacco

Illegal Drug Use: ☐ Denies any illegal drug use ☐ Admit to illegal drug Use:_____

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ NO

Past Medical History

Please check all that apply

General / Medical:

☐Cancer – Type ☐Diabetes – Type_____ ☐ HIV/ AIDS

Head/Eyes/ Ears/Throat/Neurological

☐Glaucoma ☐Headaches ☐Head Injury ☐ Hyperthyroidism ☐Hypothyroidism ☐Migraines ☐Stroke

Cardiovascular/Hematology

☐Anemia ☐Bleeding Disorders ☐Coronary Heart Disease ☐Chest Pain ☐ Heart Attack ☐ Murmur

☐Fainting ☐High Blood Pressure ☐High Cholesterol ☐Mitral Valve Prolapse ☐ Pacemaker

☐Defibrillator ☐Phlebitis ☐ Poor Circulation ☐Shortness of Breath ☐swelling in feet ☐DVT

Respiratory

☐Asthma ☐Bronchitis ☐Emphysema / COPD ☐Pneumonia ☐Tuberculosis ☐Wheezing ☐PE

Gastrointestinal

☐Bowel Incontinence ☐ Acid reflux (GERD) ☐Constipation ☐Diarrhea ☐Vomiting ☐Hernia

Musculoskeletal

☐Amputation ☐Bursitis ☐Carpal Tunnel Syndrome ☐ Chronic Low Back Pain

☐Joint Pain ☐Neck Pain ☐Fibromyalgia ☐Joint Injury ☐Osteoarthritis ☐Osteoporosis ☐Spasms

☐Rheumatoid Arthritis ☐Tennis Elbow ☐Vertebral Compression Fracture ☐Joint Swelling

Genitourinary/Nephrology

☐Bladder infections ☐Dialysis ☐Kidney Infections ☐Kidney Stones ☐Urinary Incontinence

☐Flank pain ☐Erectile Dysfunction ☐Painful urination ☐Decreased Flow/Frequency

Hepatic / Liver

☐Hepatitis A (active/inactive/unsure) ☐Hepatitis B(active/inactive/unsure)

☐Hepatitis C (active/inactive/unsure) ☐Cirrhosis ☐Jaundice

Neuropsychological

☐Alcohol Abuse ☐Alzheimer Disease ☐Bipolar Disorder ☐Depression ☐Prescription Drug Abuse

☐Multiple Sclerosis ☐Peripheral Neuropathy ☐Suicidal thoughts ☐Stress ☐Seizures ☐RSD ☐Epilepsy

Systems Review

Systems Review: Are You **currently** experiencing any of the following: Check All that apply

General:

Loss of appetite ☐Yes ☐No

Recent Weight loss ☐Yes ☐No

Fever or Chills ☐Yes ☐No

Respiratory:

Shortness of Breath ☐Yes ☐No

Chronic Cough ☐Yes ☐No

Kidney/Bladder/Urine:

Painful Urination ☐Yes ☐No

Blood In Urine ☐Yes ☐No

Kidney Problems ☐Yes ☐No

Gastrointestinal:

Nausea or Vomiting ☐Yes ☐No

Blood in Stool ☐Yes ☐No

Heartburn ☐Yes ☐No

Constipation ☐Yes ☐No

Neurological:

Headaches ☐Yes ☐No

Seizures ☐Yes ☐No

Dizziness ☐Yes ☐No

Hematological / Lymphatic:

Easy bruising ☐Yes ☐No

Easy Bleeding ☐Yes ☐No

Endocrine:

Thyroid Disease ☐Yes ☐No

Heat / Cold Intolerance ☐Yes ☐No

Cardiovascular:

Chest Pain ☐Yes ☐No

Palpitations ☐Yes ☐No

EYES:

Blurred Vision ☐Yes ☐No

Double Vision ☐Yes ☐No

Loss of Vision ☐Yes ☐No

SKIN:

Frequent Rashes ☐Yes ☐No

Skin Ulcers ☐Yes ☐No

Lumps ☐Yes ☐No

Head/Ears/Nose/Throat:

Hoarseness ☐Yes ☐No

Trouble Swallowing ☐Yes ☐No

Hearing Loss ☐Yes ☐No

Last Seizure:_____

Psychiatric

Depression ☐Yes ☐No

Drug/Alcohol Addiction ☐Yes ☐No

Suicidal Thoughts ☐Yes ☐No

Do you Have a Pacemaker: ☐**Yes Brand:** _____**Cardiologist:**_____ ☐**No**

Do you Have a Defibrillator: ☐**Yes Brand:**_____**Cardiologist:**_____ ☐ **No**

Do you have a Spinal Cord Stimulator: ☐**Yes** ☐:Cervical ☐Lumbar ☐Peripheral ☐**No**

Brand:_____**Year Placed:**_____**Hospital:**_____

Are you using it? ☐Daily ☐As needed ☐Continuous ☐Intermittent

Have we failed to ask anything that you believe is important for us to know?

_____

_____

_____

_____

I hereby certify that the above information is true and correct to the best of my knowledge:

Patient / Representative Name:_____

Patient Signature:_____ **Date:**_____

PRIVACY QUESTIONNAIRE

Please list any persons whom you authorize this office to inform about your general medical condition (including treatment, payment and other health care operations).

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

Can confidential messages regarding your treatment be left on your telephone answering machine? ☐**Yes** ☐ **No**

Initial _____

OSTEOPATHIC MANIPULATIVE TREATMENT

We utilize Osteopathic Manipulative Treatment (OMT) to offer relief from pain and improve bodily function. OMT is a form of treatment based on the concept that the structure of the body influences function. The goal of OMT is to improve the body's structure. OMT procedures are performed at areas of somatic dysfunction based upon the physician's evaluation.

Risks and benefits of OMT are discussed during appointments by physicians.

Initial _____

CONSENT FOR TREATMENT

I give consent for treatment and services that are considered medically necessary to my care.

I understand that at any time this office feels in good faith that it can no longer provide me medical care or there is no longer a working doctor-patient relationship, I will be informed of this. Furthermore, I understand that under Virginia statue I will have 30 days to find another physician. Upon written request, this office will then forward my medical records to my new provider.

Initial _____

RECEIPT OF PRIVACY PRACTICES (condensed version)

I have received a copy of the condensed version of Pain Management Associates "Notice of Privacy Practices" and have had access to the full version posted in his office. I understand that I can request copies of either version at any time.

I understand my rights and responsibilities with regard to maintaining the privacy of my health records, and know that if I need additional information or if I wish to give further instructions, I can contact the practice privacy officer via 434-975-2555.

Initial _____

Patient Signature: _____ Date: _____

Printed Name: _____ DOB: _____

Rev 3/11

ALBEMARLE
PAIN MANAGEMENT ASSOCIATES

Pain Management Associates
630 Peter Jefferson Parkway, Suite 170
Charlottesville, VA 22911

FINANCIAL POLICY

To ensure that we are able to continue providing quality care to our patients,

the following financial policies shall be enforced:

Payment Responsibility

The patient or his/her legal representative is ultimately responsible for all charges incurred.

Assignment of Benefits

As a courtesy to our patients we will bill their insurance plan. We will do so only if the patient provides the required insurance information. We will make every effort to help our patients understand their insurance; however it is ultimately the patient's responsibility to be familiar with their health insurance plan. Please bear in mind that your insurance is a contract between you, your employer and your insurance company, of which we are not a party. We cannot guarantee payment of claims, and a reduction or rejection of your claim does not relieve you of your financial obligation. In the event that your insurance plan sends you a check for payment of services rendered in this office, we ask that you please make this check payable to us at the time of receipt. If this is not done, the patient will then become responsible for the outstanding balance.

Self-Pay Patients / Non-Covered Services

Payment for all charges which are not covered by insurance may be requested and are due at the time services are rendered. If the patient is unable to make full payment on these charges, it may become necessary to request for a payment arrangement to be made.

Prior Unpaid Accounts

Prior to providing services, payment of outstanding accounts may be requested. At this time, payment should be received or a payment arrangement may be requested. Patients with unpaid delinquent accounts may be denied treatment if not medically required.

Payment Arrangements

If a patient is unable to make full payment of the patient balance when due, periodic partial payments may be arranged through CareCredit, a service offered by GE Capital Consumer Card Co. A patient financial evaluation may be requested to determine appropriate payment arrangements.

Methods of Payment We accept cash, checks, CareCredit, VISA and MasterCard.

Return Check Fees There is a $35.00 fee for checks returned due to insufficient funds.

Referral for Outside Collections Accounts which cannot be collected after normal in house collection procedures may be referred to an outside agent for further collection action. Additional fees for these services may be charged to the patients' account.

Hardship Accounts If a patient is determined to have financial hardship, we will assist the patient in applying for other financial assistance. If no source of financial assistance in available, the patient's account will be reviewed for a charitable allowance.

No-Show Fees If the patient is unable to attend their appointment, our office must be notified ***AT LEAST*** 24 hours before the scheduled appointment time. If the patient's appointment is scheduled on a Monday, we must be informed ***NO LATER THAN*** 10:00 a.m. the previous Friday. If we are not notified within these time frames, a no-show fee of **$50.00** will be charged directly to the patient. This fee must be paid in full before the patient's next appointment.

Refunds Overpayments will be refunded to the appropriate party. Patient refunds will not be processed until all active or past due accounts are paid in full. Refunds of less than $5.00 will not be issued unless specifically requested.

Contact Insurance Company on the Behalf of the Patient To authorize patients for appointments, we speak to insurance companies directly on behalf of the patient. Patient grants permission for us to do so without reservation.

I understand and agree to the above defined financial policy of *Pain Management Associates.*

Patient Signature: _____ Date: _____

Patient Name: _____ DOB: _____

ALBEMARLE
PAIN MANAGEMENT ASSOCIATES

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630 Peter Jefferson Parkway, Suite 170
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NOTICE OF PRIVACY PRACTICES - CONDENSED VERSION

PLEASE REVIEW THIS DOCUMENT CAREFULLY. Please feel free to **ask for assistance** if reading printed English or understanding what is written is difficult for you - we are glad to help!

This notice describes how your health information may be used and disclosed, and how you can get access to this information. This is a "condensed version" of the full privacy notice. If you have any questions about this notice, or if you want a copy of the extended version, please contact our Privacy Officer. Contact information is listed below.

WE RESPECT YOUR RIGHT TO PRIVACY:

Pain Management Associates (PMA) is committed to protecting the confidential nature of your medical information to the fullest extent of the law. In addition to various laws governing your privacy, PMA has its own privacy policies and procedures in place. These are designed to protect your information. PMA will continue to make protecting your privacy a priority. ***Unless you give us a written authorization, we cannot use or disclose your health information for any reason except for those described in this notice.***

OUR LEGAL DUTY:

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law. The PMA is required by HIPAA to provide you with this notice. This notice describes PMA's privacy practices, legal duties, and your rights concerning your Protected Health Information. PMA must follow the privacy practices described in this notice while it is in effect. This notice takes effect **April 11, 2005**, and will remain in effect until the PMA publishes and issues a new notice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

We routinely use and disclose health care information about you for treatment, payment, and healthcare business operations. Please keep in mind that in all cases, we will use and disclose *only the minimum amount of information necessary* to accomplish the necessary tasks. For example:

Your Authorization: You may give us written authorization to use or disclose your health care information for any purpose without restrictions. If you give us such authorization, you may revoke it at any time by submitting a written notice. Your revocation of blanket authorization for use and disclosure of health care information cannot be retroactively applied to any use or disclosures permitted while your authorization was in effect.

Treatment: We may use or disclose your health care information to other healthcare providers who also treat you, and we may disclose, with your permission, the information necessary for your family/significant others to assist in your care.

Other Persons Involved in Your Care: In an urgent event in which you are unable to communicate your needs to us, we may use or disclose your health care information to find and notify a family member or other person designated as responsible for your care, and we may inform them of your location and condition. We will also use our professional judgment and experience with common practice to make reasonable assumptions in allowing another person to assist you by picking up prescriptions, medical supplies, diagnostic imaging films, records, or other similar forms of health information.

Payment: We may use or disclose your health care information to obtain pre-authorization or payment for services we provide for you.

Health Care Operations: We may use or disclose health care information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment/improvement activities, employee competency review activities, training of healthcare providers and students, obtaining necessary licenses, accreditations, certifications and credentials, and communicating with third party "business associates" that perform various activities for our practice. (For example, billing or transcription services.)

Marketing Health-Related Services: As a courtesy to you, we will *not* use your health information for marketing communications without your written authorization.

Appointment Reminders: We may use or disclose your health care information to provide you with clarifications or reminders about the details of your appointments via voicemail messages, postal mail, or e-mail. If you do not wish to receive appointment reminders, you may, as in any situation, limit or direct our use and disclosure of your health care information by submitting a written request.

Other Permitted and Required Uses and Disclosures of Health Care Information *NOT* Requiring Authorization:

Although many urgent situations allow us to disclose your protected health information without your authorization or without providing you the opportunity to agree or object, we will first attempt to inform you of our intent to use or disclose your health care information. These situations include: disclosures required by statutory law, legal proceedings or law enforcement activities, public health concerns, communicable disease reporting, potential abuse or neglect, health oversight (regulatory) activities, workers' compensation laws, military activities, national security concerns, and requests from governmental agencies such as, but not limited to the Food and Drug Administration (FDA) and the Centers for Disease Control (CDC).

YOUR RIGHTS:

You have the right to inspect and copy your protected health information. This means you may inspect and/or obtain a copy of your protected health information (medical/billing records) for so long as we maintain the protected health information. We may charge you a reasonable copy fee for a copy of your records, typically $0.50 per photocopied page and applicable postage. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. You may request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do agree, we will make every effort to comply with your wishes, except in cases of emergency.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.

You may have the right to have your physician amend your protected health information. You may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment and refer you to our Privacy Officer for guidance as to your options for formally disagreeing with the denial to amend the record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices.

You have the right to obtain a paper copy of this condensed notice and/or the full extended notice from us, upon request, even if you have agreed to accept this notice electronically.

QUESTION OR COMPLAINTS:

If you have questions or concerns about your privacy rights, please contact us.

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You are encouraged to notify our Privacy Officer of your concerns; contact information is listed below. We welcome the opportunity to listen to you in order to address your concerns and improve our services, and we will not retaliate against you for filing a complaint.

You may contact our Privacy Officer for assistance with special instructions, authorizations, questions or complaints.

Privacy Officer: Jenny Highlander, Office Manager

Telephone: 434.975.2555 ext 106 // Fax: 434.974.6900

Address: Pain Management Associates, 630 Peter Jefferson Parkway, Suite 170, Charlottesville, VA 22911