ACCOUNT: _____

Revised 05/22

MEDICAL CARE

"Medical Care with a Heart."

www.medicalcarepllc.com

PHONE: (423)929-2584 • **FAX** (423) 722-2060

PLEASE USE BLACK INK AND PRESS FIRMLY

Thank you for taking time to fill out the information below. it is necessary for Medical Care, PLLC to update each patient's chart annually in order to serve the patient's medical needs. Please make sure each question is answered correctly. Incorrect or missing information can result in insurance filing problems and/or failure to contact the patient with important information.

PATIENT INFORMATION

Name: _____ Middle: _____ Last: _____

Date of Birth: _____ Street (include Apt/Lot#): _____

City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

Phone Home:(____)_____ Daytime/Work:(____)_____ Mobile:(____)_____

Patient's Social Security Number: _____ Marital Status: _____

Emergency Contact:(_____)_____ Name/Relationship: _____

E-Mail: _____ Decline _____ Do not have _____

Preferred Communication Method: Phone _____ Mobile _____ Text _____ E-Mail _____ Letter _____

Birth Sex: Male _____ Female _____ Hispanic/Latino: Yes _____ No _____

Race: White _____ Black/African American _____ Asian _____ American Indian/Alaskan _____ Other _____

Primary Language: ENGLISH ☐ SPANISH ☐ CHINESE ☐ KOREAN ☐ OTHER ☐

Is Medical Care your primary care provider (PCP): Yes _____ No _____ If not, who is your PCP? _____

Payment Information: CASH ☐ PRIVATE INSURANCE ☐ MEDICARE ☐ TNCARE ☐

RESPONSIBLE PARTY (REQUIRED IF PATIENT IS UNDER 18)

Name: _____ Middle: _____ Last: _____

Street (include Apt/Lot#): _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

Relationship to patient: _____ If a student, name of school: _____

INSURANCE CARD INFORMATION (IF PATIENT'S NAME IS DIFFERENT THAN CARD)

Name: _____ Middle: _____ Last: _____

Date of Birth: _____ Social Security Number: _____

Relationship to patient: _____

Revised 08/22

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Gray Office
132 Old Gray Station Road

Johnson City Office
401 East Main Street

Elizabethton Office
1500 West Elk Avenue

Hampton Office
437 Highway 321

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MEDICAL RECORDS & PATIENT INFORMATION CONFIDENTIALITY POLICY

In compliance of state and federal regulations, Medical Care will not release an individual's medical records or information without the patient's written authorization. The patient may restrict or revoke the authorization to release medical information at any time. We ask that you instruct us on what medical information can be shared, with whom, and by what means of communication.

May Medical Care contact you by phone and, if no answer, leave a message for appointments, referrals, scheduling, prescriptions, labs, or other test results, etc.?

☐ **YES** ☐ **NO**

Preferred method of communication for service reminders such as scheduling/referrals, statement reminders, appointment reminders, and medical test results:

☐ Cell Phone ☐ Home Phone ☐ Letter ☐ Email

May we text you? ☐ Yes ☐ No Cell Phone Carrier: _____

If Medical Care cannot reach you, is there another person with whom we can discuss your medical information? Please list relationship/contaact phone numbers:

Name: _____ Relationship: _____ Phone# _____
Name: _____ Relationship: _____ Phone# _____
Name: _____ Relationship: _____ Phone# _____

If patientis a minor, I authorize the following people to bring my child or dependent to Medical Care for treatment:

Name: _____ Relationship: _____ Phone# _____
Name: _____ Relationship: _____ Phone# _____
Name: _____ Relationship: _____ Phone# _____

ALL PATIENTS: CASH PAY, TENNCARE, MEDICARE, AND PRIVATE INSURANCE

I consent to treatment and agree to be financially responsible for any service and to pay any charges necessary to collect, including by not limited to collection fees, attorney fees and court costs.

Signed: _____ Printed Patient Name: _____

Date: _____ Patient's Date of Birth: _____

Insurance

I authorize the release of any medical information necessary to process claims. I authorize payment of medical benefits to Medical Care, PLLC or the named provider for professional services rendered. I agree to be responsible for charges not paid by my insurance (co-poay, deductible, not covered services, etc.) We cannot bill your insurance company unless you give us your correct insurnace company; we are not a party to that contract. Please be aware that some, and perhaps all, of the services provided to you may be non-covered sercies and not considered reasonable and necessary under the Medicare program and/or medical insurance.

Paper Work (FMLA, disability, etc.)

All paper work must be completed at time of ovisit; no paperwork may be completed without patient present.

ACCOUNT: _____

Revised 05/22

DONE: _____

BY: _____

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ **Social Security:** _____

1. I authorize the use of disclosure or the above named individual's health information as described below:

2. The following individual or organization is authorized to **release/receive** the authorized health information:

Group Name: _____ **Physician Name:** _____

Address: _____

Phone Number: _____ **Fax Number:** _____

3. Medical Care, PLLC is authorized to **receive** the authorized health information:

- **Medical Care, PLLC • 1500 West Elk Avenue • Elizabethton, TN 37643**
- **Fax:** (423) 542-5109 (40 pages or less)
- **mcpllc@medicalcarepllc.medinformatixdirect.com**

4. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- All records **FOR LAST 18 MONTHS**
- Medication list
- List of allergies
- Immunization record
- Most recent history and physical
- Most recent discharge summary
- Laboratory results from (date) ____/____/____ to (date) ____/____/____ or All ____
- Radiology reports from (date) ____/____/____ to (date) ____/____/____ or All ____
- Other _____

5. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavorial or mental health services, and treatment for alcohol and drug abuse.

6. This information may be disclosed to and used by the following individual or organization for the purpose of medical treatment: **Medical Care, PLLC • 1500 West Elk Avenue • Elizabethton, TN 37643**

7. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date: _____

If I fail to specify an expiration date, event, or condition, this authorization will expire in one year.

8. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentially rules. If I have questions about disclosure of my health information I can contact medical records.

_____ _____

Signature of Patient or Legal Representative | Date

_____ _____

If Signed by Legal Representative, Relationship to Patient | Signature of Witness

Please send records to MEDICAL CARE, PLLC • 1500 West Elk Avenue • Elizabethton, TN 37643 • FAX: (423)542-5109 (40 pages or less)

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OPIOID INFORMATION AND INFORMED CONSENT POLICY

Medical Care is very conservative in the usage of any controlled medication. The purpose of this form is to educate and inform all of our patients about controlled medications risk/benefits and our policy about their usage in this practice. Please read this completely and if you desire a copy to take home, we will provide one for you.

For new patients, it is important to note that a prior prescription of opioid pain medications, benzodiazepines, or any other controlled medication does not guarantee those medications will be prescribed by our practice. A provider will assess each case individually to decide if these medications are needed. This often will require records from prior physician(s). At the first visit it should be expected that a prior chronic controlled medication will not be prescribed. We will make every attempt to treat pain, particularly chronic pain, with other options.

Every patient must provide a complete personal drug history. This includes all medications but especially prior substance abuse or addiction to any substance including marijuana, cocaine, alcohol, opiates, benzodiazepines. Prior addiction to any drug greatly increases the risk of use of all controlled medications.

If an opioid medication is needed it will only be for a trial. Continuation and any changes in dosage of the opioid medication will be determined by your provider based on pain relief, functional improvement, side effects, and adherence to instructions. The provider may change the dosage or discontinue the treatment for any reason.

Opioids are not the only option for treatment of pain. Alternative treatments include nonsteroidal anti-inflammatory drugs, steroids, muscle relaxants, gabapentinoids, physical therapy, massage, chiropractic treatments, local injections, topical therapies, and surgeries. In many cases these therapies will be preferred and chosen due to lower risk and proven efficacy. Risk and benefit of each of these therapies will be discussed on an individual basis. It is important to understand no medication can be expected to get rid of all pain. Reduction of pain is the objective of all pain control treatments. Opioid pain medications do not correct physical problems or injuries and are used only to reduce suffering and improve functionality when possible.

Taking narcotic/opioid medications while on benzodiazepines may pose certain risks and side effects. These risks and side effects include, but are not limited to, the following:

- Allergic reaction (immediately consult your provider)
- Addiction - involves compulsive use of a substance for unintended purposes. It is characterized by behavior that includes the following: impaired control over drug use, compulsive use, continued use despite harm or consequences, and cravings.
- Physical dependence on the properties of the medication. Abruptly stopping these drugs will cause a withdrawal response. If medication is stopped, or rapidly reduced in dose after prolonged use then runny nose, yawning, large pupils, abdominal pain, cramping, diarrhea, irritability, body aches, and flu-like symptoms will likely result. These can be very painful but generally not life-threatening. Physical dependence does not equal addiction. The likelihood of continued long-term use of opioids increases most dramatically after the 5th and 31st days on therapy; after the second prescription of opioids; or with 10-and 30-day supplies. (CDC, 2017)
- Tolerance - exposure to the drug induces changes that result in a lessening of the drug's effects over time
- Overdose (which can result in death by slowing breathing)
- Failure to provide pain relief
- Sleepiness, drowsiness, dizziness, confusion, slower reflexes and reactions
- Impaired judgement and inability to operate machines or drive motor vehicles
- Nausea, vomiting, and/or constipation
- Itching
- Changes in sexual function

FOR WOMEN OF CHILDBEARING AGE WITH REPRODUCTIVE CAPACITY ONLY (UNDER TENNESSEE LAW, AGES 15-44):

Risks associated with opioid use during pregnancy

The use of narcotic/opioid medication poses special risks to women who are pregnant or may become pregnant. Taking opioid pain medication or illicit opioids such as heroin during pregnancy means, the baby may be physically dependent on opioids (called "neonatal abstinence syndrome"), which is very harmful to the baby. Neonatal Abstinence Syndrome is a condition in which a new born baby had withdrawal symptoms after being exposed to opioids while in the womb. Birth defects can occur if you take an opioid during pregnancy. The long-term consequences on the development of a child who was exposed to opioids is not fully understood and cannot be predicted, but it could be harmful to the child.

Birth control counseling

If an opioid medication is to be used in women of childbearing age, birth control (or contraceptive) is needed to reduce the chances of becoming pregnant while being treated with a narcotic/opioid medication. Health care provider and prescriber will counsel each woman on appropriate and effective forms of birth control options. Without proper birth control measures opioid pain control therapy is likely not an option.

Initials of patient acknowledgement: _____

PATIENT AGREEMENT

◦ I will not use any illicit substances, such as cocaine, marijuana, amphetamines, or legal central nervous system depressants such as alcohol while taking prescribed controlled medications. Doing so will result in discontinuation of treatment and possibly discharge from this practice.
◦ If I plan to become pregnant or believe that I have become pregnant while taking an opioid medication(s), I will immediately call my obstetrician and this office to inform them.
◦ I will take any controlled medication only as prescribed and I will not change the amount or dosage frequency without authorization from my provider (except in the event of an allergic reaction). Medication prescribed (PRN), should only be taken as needed. I further understand that changes may result in running out of medications early, and early refills will not be allowed. This may result in withdrawal symptoms.
◦ I will obtain my opioid prescriptions from only my provider or during his or her absence by the covering provider. Requests for pain medications from the on-call provider (nights and weekends) will not be honored. Controlled medications will not be refilled by phone. Obtaining controlled medication by another provider may result in discontinuation of treatment or dismissal form this practice. This Controlled Substance Monitoring Database (CSMD) website will be checked regularly by the provider.
◦ The pharmacy I have selected is:
◦ I will submit to random pill counts and urine and/or blood drug tests as requested by my provider in order to monitor my treatment. I understand that the presence of any unauthorized substances in my urine or blood may prompt referral for assessment of addiction and could result in discontinuation of further opioid prescriptions. I also understand that failure to follow these rules may lead to dismissal from care by my provider after a 30-day, emergency-only time period.
◦ I will not share, sell, or otherwise permit others to have access to this medication and I will keep it in a secure location. Lost or stolen prescriptions will not be replaced.
◦ I understand a referral to a pain management specialist may be needed. If requesting referral to pain management we will make every attempt to provide that referral however the referral is not always possible if it is declined by the pain management physician.
◦ I understand the prescribing physician may stop or change medications at any time.
◦ I understand agreement to this policy does not guarantee continued treatment with controlled medications.

By signing below, I acknowledge that I have read the above information or it has been read to me and I understand all of it. I have had all of my questions regarding the treatment of pain with opioids answered to my satisfaction.

_____ _____

Patient Signature Date

_____

Printed Name of Consenting Person