New Patient Appointment
ANTIOCH

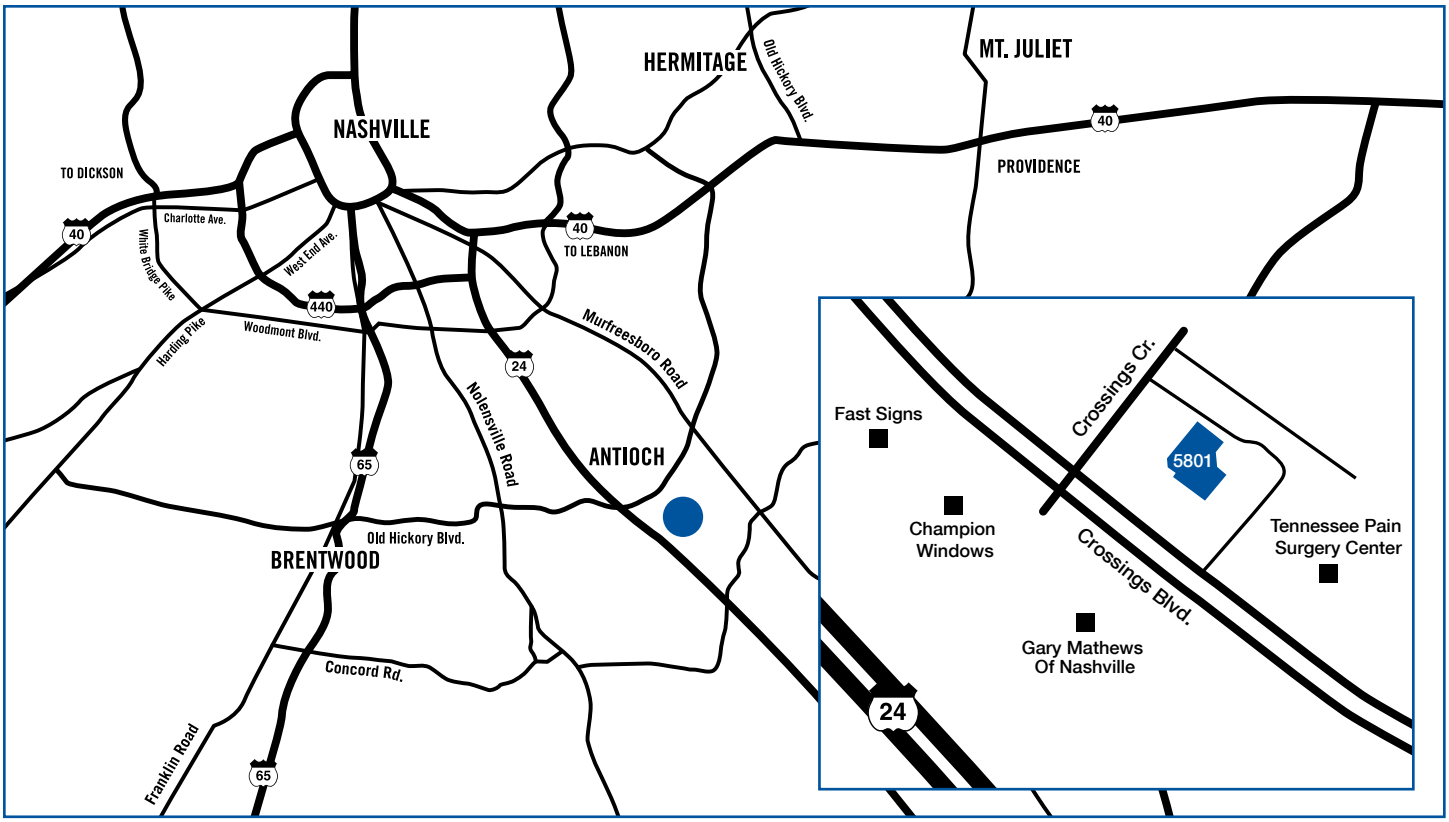
5801 Crossings Boulevard ▪ Antioch, TN 37013 ▪ 615.941.8501

DIRECTIONS:

East or West on I-40 *(towards Nashville):*
Transfer to I-24 East going towards Chattanooga - about 10 minutes later get off on exit #60 (the Hickory Hollow exit), take a right at the first light which is Mt. View Road, go one block to Crossings Blvd. and take another right. We are about a fourth of a mile the left hand side across the street from the Gary Mathews auto dealership/Champion Window's and Doors.

North on I-65 *(South of Nashville):*
Take the Old Hickory exit going East, this road will turn into Bell Road, after you have passed under I-24 go a couple of blocks until you reach Mt. View and take a right. Mt. View will soon turn into Crossings Blvd. and we are about a fourth of a mile on the left hand side across the street from the Gary Mathews auto dealership/Champion Window's and Doors.

South on I-65 *(North of Nashville):*
Follow I-65 into Nashville then transfer to I-24 East going towards Chattanooga, get off on exit #60 (the Hickory Hollow exit), take a right at the first light which is Mt. View Road, go one block to Crossings Blvd. and take another right. We are about a fourth of a mile on the left hand side across the street from the Gary Mathews auto dealership/Champion Window's and Doors.



PAIN MANAGEMENT Group pmg

Revised 3.1.2015

Name: _____ Acct#: _____ Date: _____

Referred by: _____ PCP: _____ Age: _____

CC **My chief complaint today is:** ☐ Headache ☐ Facial pain ☐ Neck pain ☐ L R Arm pain ☐ Mid-back pain
☐ Chest-wall pain ☐ Abdominal pain ☐ Low-back pain ☐ L R Leg pain ☐ Other: _____

HPI My pain began: _____ and was caused by: _____

_____

_____

Last Imaging Studies:

X-Ray: _____ Where/When: _____

CT: _____ Where/When: _____

MRI: _____ Where/When: _____

Is the cause of your pain work related? ☐ Yes ☐ No

Are there legal issues involving your pain? ☐ Yes ☐ No

The frequency of my pain: ☐ Is constant ☐ Comes and goes

My pain is best described as: ☐ Dull ☐ Sharp ☐ Aching ☐ Tingling
☐ Burning ☐ Numb ☐ Shooting ☐ Cramping

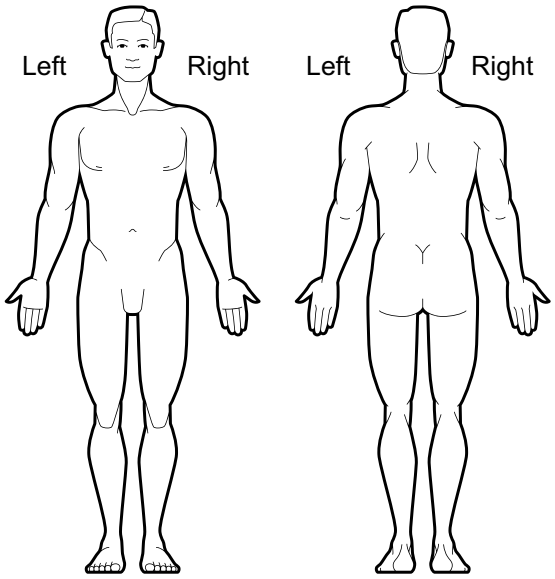
The severity of my pain:

at its best is:	0	1	2	3	4	5	6	7	8	9	10
	No pain								Unbearable		
at its worst is:	0	1	2	3	4	5	6	7	8	9	10
	No pain								Unbearable		
currently is:	0	1	2	3	4	5	6	7	8	9	10

What makes your pain worse? ☐ Lying ☐ Sitting ☐ Bending
☐ Standing ☐ Walking ☐ Other: _____

What makes your pain better: ☐ Lying ☐ Sitting ☐ Standing
☐ Walking ☐ Exercise ☐ Meds ☐ Rest ☐ Other: _____

Draw in the location of your pain below:



My pain prevents: ☐ Good sleep ☐ Daily bathing/dressing ☐ Doing home chores ☐ Walking/exercise ☐ Being employed

What treatments have you had for your pain?

☐ Psychologist ☐ TENS unit ☐ Home exercises ☐ Physical Therapy ☐ Chiropractor ☐ Trigger point injections
☐ Spine injections ☐ Surgery Which of these treatments have helped? _____

Have you been to any other pain clinic? ☐ Yes ☐ No If so, print name of clinic: _____

What medications have you tried for your pain?

☐ Amrix	☐ Baclofen	☐ Neurontin	☐ Avinza	☐ Mepergan	☐ Mirapex	☐ Lexapro
☐ Arthrotec	☐ Flexeril	☐ Keppra	☐ Codeine	☐ Methadone	☐ Requip	☐ Paxil
☐ Aspirin	☐ Norflex	☐ Gabitril	☐ Darvocet	☐ MS Contin	☐ Lidoderm	☐ Prozac
☐ Celebrex	☐ Parafon Forte	☐ Topamax	☐ Dilaudid	☐ Opana	☐ Valium	☐ Remeron
☐ Mobic	☐ Robaxin	☐ Lamictal	☐ Duragesic	☐ Oramorph	☐ Klonopin	☐ Trazodone
☐ Motrin	☐ Skelaxin	☐ Lyrica	☐ Fentanyl	☐ Oxycontin	☐ Celexa	☐ Wellbutrin
☐ Naprosyn	☐ Soma	☐ Trileptal	☐ Fioricet	☐ Percocet	☐ Cymbalta	☐ Zoloft
☐ Relafen	☐ Zanaflex	☐ Zonegran	☐ Hydrocodone	☐ Stadol	☐ Effexor	
☐ Tylenol	☐ Depakote	☐ Actiq	☐ Kadian	☐ Ultram/Tramadol	☐ Elavil	

Which of these medications helped? _____

ALL **List ALL medications that caused your allergic/adverse reactions** *(i.e., rash, shortness of breath)*? ☐ None

_____

MED **List ALL the medications are you currently taking**:_____

_____

PMH **What medical problems have you had?**

☐ Chronic Headaches	☐ Psychiatric Hospitalization	☐ Stroke	☐ Diabetes
☐ Seizures	☐ Reflux/Ulcer	☐ Heart Disease	☐ Cancer
☐ Rheumatoid Arthritis	☐ High Blood Pressure	☐ Osteoporosis	☐ Asthma
☐ Bowel Disorder	☐ Osteoarthritis	☐ Kidney Disease	☐ Peripheral nerve damage
☐ Congestive Heart Failure	☐ Heart Murmur	☐ Emphysema/COPD	☐ Depression/anxiety/Psych illness
☐ Vascular Disease/Clots	☐ Long-term Steroid Use	☐ HIV/AIDS	☐ Alcoholism/Drug Addiction
☐ Sleep Apnea	☐ Prostate Disease	☐ Abnormal heart test (EKG)	
☐ Thyroid Disorder	☐ Tuberculosis	☐ Liver Disease	
☐ Other	☐ Pancreatitis	☐ Cirrhosis/Hepatitis	

PSH

Acct#: _____ Name: _____

What surgeries have you had? ☐ Brain ☐ Ear/Nose/Throat ☐ Heart ☐ Chest/Lung ☐ Breast ☐ Stomach/Intestine
☐ Liver/Gallbladder ☐ Appendix/Bowel ☐ Spine ☐ Chest/Lung ☐ Shoulder/Elbow ☐ Hand ☐ Hip/Knee: R L ☐ Foot: R L
☐ Hysterectomy ☐ Vasectomy ☐ Hernia ☐ Other: _____

_____

_____

FH

What medical problems have your family had?

- ☐ Chronic Headaches
- ☐ Seizures
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Congestive Heart Failure
- ☐ Asthma
- ☐ Emphysema
- ☐ Prostate Disease
- ☐ Anemia
- ☐ Reflux/Ulcer
- ☐ Cirrhosis/Hepatitis
- ☐ Diabetes
- ☐ Bowel Disorder
- ☐ Kidney Disorder
- ☐ Vascular Disease/Clots
- ☐ Peripheral Nerve Damage
- ☐ Alcoholism/Drug Addiction
- ☐ Pancreatitis
- ☐ Liver Disease
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Cancer
- ☐ Long-term Steroid Use
- ☐ Depression/Anxiety
- ☐ Other: _____

SH

What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Who do you live with? ☐ Alone ☐ Spouse ☐ Family ☐ Friend(s) ☐ Parents ☐ Children: how many?_____

Work Status: ☐ Short-term disability ☐ Long-term disability ☐ Unemployed ☐ Employed part/full time ☐ Retired

Date last worked: _____ Employer: _____ Type of work: _____

Habits: Do you smoke? ☐ No ☐ Yes How many years _____How much? _____

Drink Alcohol? ☐ No ☐ Yes How much? _____ How often? _____

History of or current use of street drugs? ☐ No ☐ Yes What kind? _____ How often? _____

Drug/Alcohol rehab ☐ No ☐ Yes When? _____ Where? _____

Highest level of education completed _____

ROS

Which of the following do you currently have?

General: ☐ None
- ☐ Weight Loss/Gain
- ☐ Fever/Chills
- ☐ Night Sweats
- ☐ Frequent Infections
- ☐ Fatigue

Genitourinary: ☐ None
- ☐ Painful Urination
- ☐ Difficulty Starting or Stopping Urination
- ☐ Blood in Urine
- ☐ Sexual Dysfunction

  Male: ☐ Testicle Pain

  Female: ☐ Pregnant
  ☐ Irregular Bleeding
  ☐ Post-menopause
  ☐ Last Menstrual Cycle: _____

Head: ☐ None
- ☐ Headaches
- ☐ Facial Pain
- ☐ Visual Problems
- ☐ Hearing Disturbances
- ☐ Swallowing Difficulties
- ☐ Teeth and Gum Problems

Respiratory: ☐ None
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Wheezing

Musculoskeletal: ☐ None
- ☐ Muscle Stiffness/Pain
- ☐ Joint Stiffness/Pain
- ☐ Neck Pain
- ☐ Back Pain

Cardiac: ☐ None
- ☐ Chest Pain/Angina
- ☐ Palpitations/Irregular Heartbeat

Vascular: ☐ None
- ☐ Swelling legs

Gastrointestinal: ☐ None
- ☐ Appetite Loss
- ☐ Chronic Nausea or Vomiting
- ☐ Heartburn
- ☐ Hernia
- ☐ Constipation
- ☐ Diarrhea

Endocrine/Hematologic: ☐ None
- ☐ Poor Blood Sugar Control
- ☐ Poor Heat/Cold Tolerance
- ☐ Easy Bruising/Bleeding

Neurologic: ☐ None
- ☐ Dizziness
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tremor
- ☐ Blackouts

Psychiatric: ☐ None
- ☐ Depressed
- ☐ Anxious
- ☐ Poor Sleep

Skin: ☐ None
- ☐ Rash
- ☐ Scars

Clinician Signature: _____ **Date:** _____

Patient Information

Name: _____

Address: _____ City, State, Zip: _____

Race: ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino E-mail address: _____

Phone: (_____) _____ Alt. Phone: (_____) _____ DOB: ____/____/____ Age: _____ Sex: ☐ M ☐ F

Marital Status: ☐ M ☐ D ☐ W ☐ S SS #: _____ DL#:_____ State Issued:_____

Referring Physician: _____ Phone: (_____) _____ Primary Care Physician: _____

Are you here due to a specific injury at work or accident? ☐ Y ☐ N Explain: _____

Do you have an attorney for an injury or accident you sustained? ☐ Y ☐ N

Have you filed for Workers' Compensation benefits? ☐ Y ☐ N

EMPLOYMENT INFORMATION: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self-Employed ☐ Military ☐ Retired

Employer's Name: _____ Phone: (_____) _____ ext: _____

Address: _____ City, State, Zip: _____

SPOUSE INFORMATION:

Name: _____ Phone: (_____) _____

Employer's Name: _____ Phone: (_____) _____ ext: _____

EMERGENCY CONTACT:

Name: _____ Phone: (_____) _____ Relationship: _____

INSURANCE INFORMATION:

Name Of Primary Insurance Company: _____ Phone: (_____) _____

Address: _____ City, State, Zip: _____

Insured Name: _____ SS#: _____ Relationship: _____

Policy#: _____Group #: _____ DOB: ____/____/____ Referral Required ☐ Y ☐ N

Name Of Secondary Insurance Company: _____ Phone: (_____) _____

Address: _____ City, State, Zip: _____

Insured Name: _____ SS#: _____ Relationship: _____

Policy#: _____Group #: _____ DOB: ____/____/____ Referral Required ☐ Y ☐ N

I hereby authorize the release of any medical information to process any insurance claims. I further authorize payment of medical benefits to the physician and or facility. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I understand that failure to disclose information pertaining to work-related injuries or accidents will result in my being responsible for any charges incurred. I hereby authorize The Pain Management Group to take photographs necessary to document my physical condition.

Patient Signature: _____ Print Name: _____ Date: _____

PAIN MANAGEMENT Group pmg

Revised 3.1.2015

Patient Questionnaire

Please provide the name and phone number of a family member or other person, if any, whom we may inform about your general medical condition and your diagnosis.

Name: _____

Phone Number: _____

Do not inform anyone, other than myself, about my condition, diagnosis, or treatment.

ACKNOWLEDGEMENT OF AVAILABILITY OF NOTICE OF PRIVACY POLICIES & PRACTICES

I acknowledge being given and understand the Notice of Privacy Policies & Practices; I further acknowledge being informed that a copy of the most recent version is available to me in paper format, by request, or online at **www.thepainmanagementgroup.com.**

Patient Signature: _____ Date: _____

Patient Name *(please print)*: _____ DOB: _____

MISSED APPOINTMENT POLICY

If you are unable to make it to your appointment, we ask that you please call at least 24 hours prior to your appointment, to either cancel or reschedule. Twice failing to provide adequate notice will result in our requiring that your referring physician re-refer you, before you may reschedule..

Patient Signature: _____ Date: _____

Patient Name *(please print)*: _____

REMINDER: All co-pays and outstanding deductible amounts are due at time of service.

PAIN MANAGEMENT Group pmg

Revised 3.1.2015

Narcotic Management Agreement

This is our Narcotic Contract and Opioid Consent Form. Please read and INITIAL next to each understood statement. If you do not understand or do not agree with any statement, do NOT initial. Leave it blank and we can discuss it at your initial visit. If you have any questions, please call 615.941.8501.

INITIAL

_____ I accept admission into The Pain Management Group's service under the care of Dr. William H. Leone, Dr. Bradley Hill, Dr. Timothy Miller, Dr. Anne Perera, and Dr. Jeffrey York for treatment of chronic pain Including the use of narcotic medication as indicated under my treatment plan.

_____ I understand that using narcotics can be habit forming and acknowledge that such medications have certain risks including but not limited to physical dependence, addiction, tolerance to pain relief, sleepiness, constipation, nausea, itchy allergic reaction, slow breathing, and even death.

_____ I will not operate heavy equipment or drive while taking my medications until the side effects are known. I am aware my reflexes and reaction time may be slowed, even if I am unaware of it.

_____ I will control my usage of narcotic medications as directed by the attending physician. **There are no exceptions.** If medication is inadequate for your pain level, you **must** call before adjusting dosage.

_____ I acknowledge that the use of **ANY** illegal substances will not be tolerated.

_____ I agree to follow Instructions ordered by the attending physician and/or physician's assistant or nurse practitioner which may include participation In pain management Instructions/class, psychological counseling, exercise, physical therapy, injection therapy, non-narcotic therapy, imaging studies, referrals, diagnostic testing, etc.

_____ I agree not to seek any narcotic/pain medication from any other physicians other than The Pain Management Group. I will inform my other physicians of this narcotic agreement and request they coordinate any and all narcotic/pain medication with The Pain Management Group.

_____ I will tell my doctor about other medications and treatments I am receiving.

_____ I will receive written prescriptions for the amount and type of narcotic/pain medication established in my plan of care. I understand that I am responsible for my medication.

_____ **Lost, Stolen, or Misplaced Medication Will Not Be Replaced for any Reason.**

_____ I agree that anytime the attending physician can call me In for a pill count.

_____ I will manage my medication to prevent shortage prior to the scheduled refill date and will schedule appointments with The Pain Management Group for re-evaluation prior to being out of medication. **Repeated phone calls to obtain additional medication will not be tolerated and may result in my discharge from this clinic.**

_____ I give permission to The Pain Management Group to obtain urine and/or blood drug screening at random as deemed necessary.

_____ I give The Pain Management Group permission to share information, as needed with appropriate drug and law enforcement agencies if deemed appropriate or necessary by my physician.

_____ I agree to use a single pharmacy for my narcotic/pain medications, listed below:

Pharmacy: _____ Phone: _____

_____ I agree to take any pharmacy problems to the pharmacy and not to The Pain Management Group.

_____ **Renewal or Refill of Narcotics/Pain Medication Will Not Be Called to a Pharmacy; There are No Exceptions.**

_____ I am aware other medication such as nalbuphine (Nubain™), pentazocine (Talwin™), buprenorphine (Suboxone™), and butorphanol (Stadol™) may reverse the actions of my medications, causing withdrawl symptoms.

_____ I will be honest with my provider about my past medical history, family history, and personal drug History to prevent harm to myself.

_____ I am aware that tolerance to narcotic medications can occur and increasing doses of medications may not help and may cause unacceptable side effects.

_____ I am aware that long-term narcotic use can result in low testosterone levels.

_____ I agree that if I become pregnant or plan to become pregnant I will inform my OB/GYN of all medications I am taking.

_____ Narcotic medications and treatment may be suspended during pregnancy to prevent any birth defects.

_____ Narcotic medication may affect my mood, sexual desire and performance, physical performance and stamina.

I have read and understand the rules for narcotic control. I agree to abide by the rules of this narcotic agreement and fully understand that breach of any portion of this agreement is grounds for **immediate discharge** from any and all physicians of The Pain Management Group's medical care and/or service.

Patient Name (please print): _____ Patient Signature: _____ Date: _____

Witness: _____ Date: _____

PAIN MANAGEMENT Group pmg

Revised 3.1.2015

Attention: Patients who have Medicare or a Medicare Replacement Plan

When you sign-up for a Medicare replacement plan, you are temporarily signing over your rights to your traditional Medicare, to the company offering the replacement plan (i.e. Blue Cross Blue Shield, United Healthcare, Healthsprings, Humana, AmeriChoice, AmeriGroup, etc.).

While these plans are a replacement for Medicare, they do not work the same way as traditional Medicare. Most of these plans require a referral from your primary care physician, as well as prior authorization requirements that do not apply to traditional Medicare patients. Additionally, if you change from one replacement plan that requires a referral to a different replacement plan, any referrals or authorizations, you had on file, do not transfer. You will have to return to your primary care physician for a referral for the new plan, and most plans require the primary care physician to physically evaluate you before issuing a referral.

It is your responsibility to inform our office of any changes to your Medicare. This includes initially signing up for a Medicare replacement plan and changing from one Medicare replacement to another. It is important that you call and inform us of any changes as soon as they occur or if you anticipate· any changes in the future. Waiting until your next appointment to inform us about changes to your Medicare is too late, and will result in your visit being rescheduled until we are able to obtain a referral. Please call **615.941.8501,** and press “0” to speak with the operator. Tell her that you have new insurance and she will transfer you to the appropriate person.

PAIN MANAGEMENT Group pmg

Revised 3.1.2015

Notice of Privacy Policies & Practices

THIS NOTICE. DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health pain information about you so that they will pay for your treatment

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your-Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort

Research. Under certain circumstances**,** we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included In their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your Information and are not allowed to use or disclose any information other than as specified In our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

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Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health Information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information In response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the Information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors all necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved In Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement In your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Health Information to coordinate your care, or notify family and friends of your location or condition In a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with our written authorization if you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to: Attn: Health Information Manager, 5801 Crossings Blvd., Antioch, TN 37013. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other slate of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided In either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have Is incorrect or incomplete, you may ask us to amend the Information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, In writing, to: Attn: Health Information Manager, 5801 Crossings Blvd., Antioch, TN 37013.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to: Attn: Health Information Manager, 5801 Crossings Blvd., Antioch, TN 37013.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to: Attn: Health Information Manager, 5801 Crossings Blvd., Antioch, TN 37013. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you with to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

R**ight to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to: Attn: Health Information Manager, 5801 Crossings Blvd., Antioch, TN 37013. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.thepainmanagementgroup.com. To obtain a paper copy of this notice, you may request a copy from the receptionist, call the office at 615-941-8501, or request in writing to: Attn: Health Information Manager, 5801 Crossings Blvd., Antioch, TN 37013.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the bottom left-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer, 5801 Crossings Blvd., Antioch, TN 37013. All complaints must be made in writing. **You will not penalized for filing a complaint.**

PAIN MANAGEMENT Group pmg

Revised 3.1.2015