VALLEY
PAIN CONSULTANTS
In Partnership with ValleyHealth

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1818 Amherst St. Suite 201 Winchester, VA 22601
Phone: (540) 450-2339 Fax: (540) 450-2333

Dear Patient,

Enclosed is the Valley Pain Consultants new patient packet. Please complete **ALL** of the paperwork included in this packet and **bring it with you to your appointment.** If completed, arrive 15 minutes early. If you cannot complete the paperwork**, arrive 30 minutes early** in order to complete it.

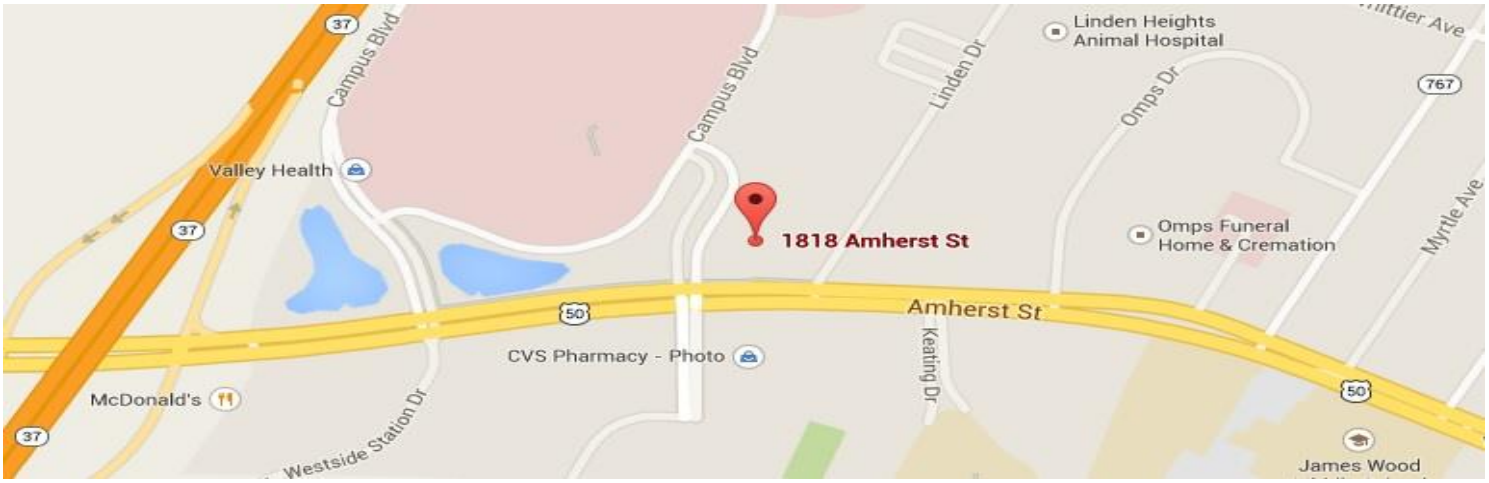
Please bring the following information with you to your appointment:

- **Insurance card(s), Photo I.D., Co-payment if applicable**
- **A list of the medications that you are currently taking**
- **Any imaging films and the corresponding reports that you were instructed to bring**

We realize that the content of information being received at your appointment can be very detailed and dealing with pain can be very distracting; however, we encourage you to bring someone to the appointment to assist you.

If you are unable to keep your appointment, please telephone us at (540) 450-2339 at least 24 hours in advance. **Please**, **arrive *15* minutes early to *ALL* appointments so we can get you checked in.** Arrival more than 15 minutes past your appointment time will result in your appointment being rescheduled.

If you should have any questions, please feel free to contact our office at (540) 450-2339. Thank you very much for choosing our practice for your pain management needs.



Directions from North Traveling South:
•Take I-81 South
•Take Exit 317
•Turn Right onto Route 37 South
•Take Route 50 (Winchester Romney) Exit
•Turn Left onto Amherst Street
•After Third light make a U-Turn, then turn Right into VBSC

Directions from South Traveling North:
•Take I-81 North
•Take Exit 310
•Turn Left onto Route 37 North
•Take Route 50 (Winchester Romney) Exit
•Turn Right onto Amherst Street
•After the Second light make a U-Turn, then turn Right into VBSC

APPOINTMENT INFORMATION

Appointment Date: _____ Your Provider: _____

Appointment Time: _____ Please Arrive By: _____

PATIENT INSTRUCTIONS

Thank you for choosing our physicians at Valley Pain Consultants for your health care needs. We are committed to providing the very best medical care and treatment. The following is a description of some of our practice policies and guidelines for patients. Please read this before your first appointment.

MEDICATION MANAGEMENT: Valley Pain Consultants does not provide narcotic medication management services to our patients. If you require narcotic medication management please consult your primary care to obtain a referral that will better suit your needs.

PRESCRIPTIONS: All medication refills are done during working hours on Monday through Thursday only. You may have your pharmacy call directly to request a medication refill. Please allow two working days for the prescription to be processed. If you need a new written prescription, please allow 5-7 business days for the prescription to be processed. We are unable to refill prescriptions after hours so allow enough time before your prescription runs out. There is a $10 recovery fee for all prescriptions that are sent via certified mail.

MISSED APPOINTMENTS: Please notify us as soon as possible if you are unable to keep a scheduled appointment. We require a minimum of 24 hours' notice so that we can use this time for someone else who is waiting for an appointment. Abusive missed appointments will result in your dismissal as a patient.

RESCHEDULING: As we are a procedural practice, emergency situations arise that may result in the physician being called away to the procedure room. As a result, your appointment may need to be delayed or rescheduled. We will do our best to notify you in order to give you the opportunity to reschedule before arriving for the appointment. During these times we appreciate your patience and understanding.

MEDICAL RECORDS: To obtain copies of your medical records you must sign a Medical Release form. There is also a small fee of $10.00 plus $0.50 per page. These fees, set forth by Virginia State law, must be paid in full before your request will processed. Please allow 7-10 business days for processing. Fees are subject to change without notice.

FORMS: Our practice does not complete forms for disability. Forms, including, but not limited to, disability or worker's compensation, will be filled out at the physician's discretion. The fee for completion of these items is $35 per form. All fees must be paid in full before the forms will be produced. Please allow 7-10 business days for processing.

EMERGENCIES: If you have a health care emergency call 911. For routine questions and concerns or for prescription refills, please call our office at (540) 450-2339. If your call is not immediately answered by our staff then please leave a message and your call will be returned in order of priority within 24 hours.

NEEDLE STICK POLICY: I authorize any physician, hospital, or medical care facility to provide all my medical history and treatment to Valley Pain Consultants. I authorize Valley Pain Consultants, to test my blood for hepatitis and for the AIDS virus, if in their opinion, an employee of Valley Pain Consultants has suffered an exposure incident as a result of my treatment defined by the Occupational Safety and Health Administration. A law was enacted in 1989 and amended in 1993 which authorizes health care providers to test their patients for HIV, Hepatitis B and C antibodies when the health care provider is exposed to the body fluid of a patient in a manner which may transmit these antibodies. Pursuant to this law, in the event of such exposure, you will be deemed to have consented to such testing and to the release of the test results to the health care provider who may have been exposed. You will be informed prior to your blood being tested for HIV, Hepatitis B or C antibodies. The testing will be explained and you will be given the opportunity to ask any questions.

MEDICAL STAFF PHONE DIRECTORY: A directory of phone numbers is included below if you need to reach members of our medical staff quickly. We try to return phone calls within 48 hours (please note we are closed on all major holidays and weekends). If you are unsure which number you should dial but still need to reach our office, you can call (540) 450-2339

Triage Line for Current Patients: (540) 450 – 8550
Main Phone Line, Medical Records & Forms: (540) 450 – 2339
Patient Financial Counselor: (540) 771 – 2297

Medical Assistant for Christy Andrews, NP-C: (540) 771 - 2306
Medical Assistant for Sharara Kazimi, NP-C: (540) 771 - 2307
Medical Assistant for Dr. Poss & Dr. Ashcraft: (540) 771 - 2304

Front Patient Information Sheet

Patient's Full Name (First – Middle – Last)	Sex: M ☐ F ☐	Patient's Birth Date	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Mailing Address City State Zip		Cell Phone: Home Phone:	Patient's Social Security #
Physical Address (If different from above)		City, State	Zip
Responsible Party Name *Relationship?* →	☐ Self ☐ Spouse ☐ Parent	Resp Party's Birth Date	Responsible Party's SSN
Responsible Party Address ☐ *Same as Patient* City State Zip Drivers License State: Number:			Preferred method of contact o Text o E-Mail
Emergency Contact Name:		Emergency Contact Phone Number:	
Name of Employer Business Phone:		E-Mail Address:	

Consent for and Use of Confidential Information of Notice of Privacy Practices

I hereby give my consent to Valley Pain Consultants to use or disclose, for the purpose of carrying out treatment, payment, or health care operation, all information contained in my private health record.

I understand consent given is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I understand that I have the right to request that the practice restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that the practice does not have to agree to such restrictions, but that once such restrictions are agreed to, the practice and their agents must adhere to such restrictions.

Due to HIPAA, we are not permitted to release information regarding your care. If you wish to grant your permission, please list below the person(s) that we may speak with on your behalf. Please be aware those listed below will be given full access to your Private Health Information.

1) _____

Name and Relation to Patient

2) _____

Name and Relation to Patient

3) _____

Name and Relation to Patient

Signature: _____ Date: _____

Pain Evaluation Information Packet

Patient Name: _____ Date: _____

Medication List

Please list all allergies (medications, environmental, etc.): _____

Please list all current medications (Rx'd, OTC and Supplements), the dosages, and the prescribing doctor (or attach list):

1) _____ 11) _____
2) _____ 12) _____
3) _____ 13) _____
4) _____ 14) _____
5) _____ 15) _____
6) _____ 16) _____
7) _____ 17) _____
8) _____ 18) _____
9) _____ 19) _____
10) _____ 20) _____

Your Pharmacy: _____ **Primary Care Physician: _____**

Please list all doctors/providers with their specialty, which are currently treating you. (Eye dr, Cardiologist, etc.)

_____

_____

_____

Family History: Please list any diseases your relatives have/had.

Mother: _____ **Father**: _____ **Siblings**: _____

PATIENT Past Medical History: Are **<u>you</u>** being treated for or have you been diagnosed with or do you have the following:

A-Fib/Flutter	Factor V Leiden	Osteoporosis	Cardiac Monitor
Anxiety	Fibromyalgia	Pulmonary Embolism	Cochlear implant
Cancer	Glaucoma	Rheumatoid Arthritis	Defibrillator
COPD	Hyper/Hypotension	Scoliosis	Pacemaker
Diabetes	Lyme's disease	Thrombocytopenia	Spinal Cord Stimulator
Depression	Multiple Sclerosis	Other: _____	
DVT	Osteopenia	_____	

List all Surgeries

Date: Surgery Hospital: Surgeon's/Physician's Name:

_____

_____

_____

_____

_____

_____

_____

_____

Past Medical Testing: Please indicate when and where if you have undergone any of the following tests.

CT Scan (Spine) _____

MRI Scan (Spine) _____

EMG/Nerve Conductions _____

X-rays _____

Dexa Scan_____

Bone Density Scan_____

Social Habits

Please truthfully answer the following questions so that we can provide safe and effective care.

Are you currently smoking? Yes No Smoking since? _____ How many cigarettes/cigars per day? _____

Have you ever smoked? Yes No Started when? _____ Stopped when? _____

Do you drink alcohol? Yes No How many drinks per week? ____ Have you ever been arrested for a DUI? Yes No

Have you ever used illicit drugs within the past year? Yes No If Yes, what? Marijuana Cocaine Heroin Amphetamine Other:_____

Have you had any drug charges in the past? Yes No Have you ever been treated for substance abuse? Yes No

Pain

Have you been treated at another pain management facility in the past? Yes No

If **Yes**, Name of the Facility _____When? _____

Have you previously had injections on this area? Yes No

Have you ever attended Physical Therapy? Yes No If Yes, when? And was it helpful? _____

Have you ever used a TENS unit in the past? Yes No

Where is the location of your most severe pain? _____

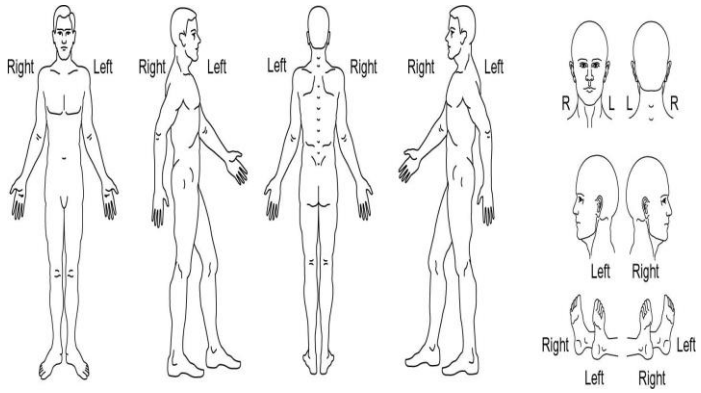
How long has this been present? _____

What is your current pain level (0-10)? *See Pain Scale* _____

(0-10 Pain Scale)

0 **No Pain**
1 **Minimal** – Hardly noticeable
2 **Mild** – Low level of pain
3 **Uncomfortable** – Pain bothers me, but can be ignored
4 **Moderate** – Constantly aware of pain, can still do most things
5 **Distracting** – I think about my pain MOST of the time.
6 **Distressing** – I think about my pain ALL the time.
7 **Unmanageable** – I am in pain ALL the time
8 **Intense** – My pain is so severe that it is hard to think of anything else.
9 **Severe** – My pain is all I think about, I can barely talk or think because of my pain.
10 **Unable to move** – I am in bed and can't move due to the pain, I need someone to take me to the ER to get help for my pain

Please shade areas of pain



How often is the pain present? Constant frequently (several times each hour) sporadic (several times each day) Occasional (several times each week) rare (several times each month)

What words best describe your symptoms? Sharp burning shooting dull throbbing aching stabbing

Do you have any of the following symptoms? Numbness tingling weakness headaches

What makes your pain better? rest heat ice stretching medication _____ other_____

What makes your pain worse? lying sitting standing walking bending/twisting emotional stress moving from sitting position to standing cold weather hot weather other_____

What is the most physical activity that you are able to do?_____

What simple goal would you like to be able to do? _____

What medication (including over the counter) do you take for your pain? _____

Approximately what *percent* improvement does the medication provide? _____

What medications have *failed* to help? (Including over the counter)_____

Have you ever tried any of the following Neuropathic medications? Please circle what applies

Gabapentin/Neurontin Lyrica Cymbalta Topamax/Topiramate None

Patient Portal Access

Patient Portal Access is the all-in-one personal health record and patient portal that lets you access your health information. You will have 24/7 online access from any computer, smartphone, or tablet. You will be able to view test and lab results, send and receive secure online messages, request Rx refills, cancel appointments, and receive email care reminders. You can also download the free portal app at your Apple or Android store (enter MyHealthRecord.com in the search field).

Complete this form in its entirety and you will then receive an email from My Health Record with instructions on setting up your personal Patient Portal Access account. You must register your new account from a computer only, you cannot create an account on a tablet or smartphone. After your account is created, you will be able to access your account from any device (computer, smartphone, or tablet). **Please complete this form if you have a valid email address, as we cannot submit your request without it.**

First Name: _____

Last Name: _____

Birth Date: _____

Last Four of SSN: _____

Valid Email Address (Please Print Clearly):

_____

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

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 to 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 plan 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.

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

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.

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.

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.

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 your 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:

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 Valley Pain Consultants, 1818 Amherst St., Suite 201, Winchester, VA 22601. 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.

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.

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.

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. 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 wish 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.

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.vpc.com

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 top right-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 Amy Maynard, Office Manager. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

You may contact our office at:

Valley Pain Consultants, 1818 Amherst St., Suite 201, Winchester, VA 22601 or by calling (540) 450 - 2339.