



***Pain Management Partners, LLC***

James Morris M.D., Sharon Jones, ANP, Carolyn Buel, ANP

2401 River Road, Suite 101 ♦ Eugene, Or. 97404

Phone: (541) 344-8469 ♦ Fax: (541) 687-8631

[www.oregonpainmanagement.com](http://www.oregonpainmanagement.com)

Dear Pain Patient,

We welcome you to our office. We strive to offer the best patient care with a multidisciplinary approach. We have enclosed:

1. Registration form.
2. Confidential medical history form.
3. Privacy Policy.
4. Cancellation Policy.

The registration and medical history forms must be completed and returned to our office within two weeks or we cannot schedule your appointment. Please keep your privacy policy.

We will schedule your appointment once we have received all medical records, registration and medical history forms back into our office. These are very important. Please call if you have any questions.

Arriving at our office, you will meet our front office staff. They perform critical functions in welcoming you, scheduling appointments, obtaining referrals, and maintaining your medical record. They work hard to create a positive experience for you. They ensure our office follows insurance and governmental regulations. They will ask you if your demographics or personal information is current. You will be asked for your insurance card for photocopying.

You are part of our team. Together we can create a positive atmosphere of excellent communication, cooperation and caring for each other. If you have questions regarding your account or wish to speak to another staff person, our front office personnel will help you. As part of the team, you can help us provide the best possible service and experience for you. Our front office personnel represent our practice and are there to assist you. Thank you for your cooperation and for becoming part of our team.

Sincerely,

***Pain Management Partners, LLC***

PATIENT REGISTRATION FORM

PATIENT LAST FIRST MIDDLE Initial

ADDRESS STREET CITY ZIP

HOME PHONE CELL # WORK#

EMAIL:

SSN# DATE OF BIRTH Sex

MARRIED SINGLE DIVORCED SEPARATED WIDOW (ER)

RACE ETHNICITY LANGUAGE

OCCUPATION EMPLOYER

\*\*\*\*\*

EMERGENCY CONTACT PHONE OTHER THAN HOME NUMBER

RELATIONSHIP TO PATIENT

REFERRED BY : DOCTOR FRIEND RELATIVE YELLOW PAGES OTHER

\*\*\*\*\*

WE WILL BILL ALL INSURANCE CARRIERS AS A COURTESY TO OUR PATIENTS. IF YOU WOULD LIKE US TO BILL YOUR INSURANCE, PLEASE PROVIDE THE REQUIRED INSURANCE INFORMATION IN ORDER FOR US TO DO SO.

FIRST INSURANCE COMPANY NAME GROUP NUMBER

INSURED PARTY LAST FIRST M.I. INSURED ID#

PATIENT'S RELATION TO INSURED INSURED DOB

EMPLOYER THROUGH WHICH YOU HAVE COVERAGE

SECOND INSURANCE COMPANY NAME GROUP NUMBER

INSURED PARTY LAST FIRST M.I. INSURED ID #

PATIENT'S RELATION TO INSURED INSURED DOB

EMPLOYER THROUGH WHICH YOU HAVE COVERAGE

I understand that I am financially responsible for all charges for the services rendered to me. I authorize release of any information necessary to process my insurance claims and I hereby authorize payment of benefits due to me to be made directly to the doctor. I understand that Medicare may deny some charges and I will be responsible for payment. Co-pays are due at time of Service.

Signed Date

I have been given a copy of the office "Privacy Policy." Please initial here

I have been given a copy of the "Cancellation Policy." Please initial here



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*CANCELLATION POLICY*

Our Providers reserve time especially for you. Missed or canceled appointments compromise our ability to address your medical needs, and block our ability to refill your medications.

24-hour business day notice is required to reschedule or cancel your medical appointment.

Any combination of 3 unexcused missed appointments in a one-year time span, such as calling and canceling the same day, or missed appointments, compromises your medical care and will result in a dismissal from this practice.

Sincerely,

Pain Management Partners, LLC

## PRIVACY POLICY

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.

If you have questions about this notice, please contact our Privacy Officer, Trina Thomas at 541-431-0631 \* 2401 River Road, Suite 101 \* Eugene, Oregon 97404.

### **Who will follow this notice?**

This notice describes the information privacy practices followed by our physicians, employees and other office personnel.

### *Your Health Information*

This notice applies to the information and records we have about your health, health status, and the healthcare and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

### **How we may use and disclose health information about you:**

We may use and disclose health information about you for the following purposes:

#### **For Treatment:**

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to physicians, medical or office staff from our office or other offices, technicians, hospital staff, or other people who are involved in taking care of you and your health.

Your doctor may be treating you for a medical condition and need to consult with other physicians or technicians about test results. The doctor may need to obtain your medical history from other offices to assist with your treatment. Your doctor may share your health information with another physician to assist that physician with your care.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate care, such as phoning in prescriptions to your pharmacy, scheduling tests at other healthcare facilities, or referring you to a specialist for care.

If you or another entity request that we provide copies of your records and the request is not specific, we will send copies of the past one years of clinical notes, tests and reports, and the past one years of lab reports.

The following records will not be released without specific written permission, except where required by law:

- A. HIV status

PRIVACY POLICY (CONT.)

- B. Information about drug/and or alcohol treatment, with description of information included (per Federal Regulation, 42, CFR Part 2)
- C. Information on mental health/psychiatric care

**For Payment:**

We may use and disclose health information about you so that the treatment and services you receive at our office may be billed to, and payment may be collected from, an insurance company or other party.

We may give your health insurance company information about why you were seen here so that they will pay us, or reimburse you, for care provided by our office. We may also give information to your health plan so that a service your doctor has recommended may be prior authorized, or we can determine whether or not the service will be paid for by the insurance company. If we are reporting information regarding a work-related or motor vehicle accident injury or problem, we will only send notes pertinent to the specific problem relating to the injury.

**For Health Care Operations:**

We may use and disclose health information about you in order to run our office and make sure that you and other patients receive quality care.

We may send you an appointment reminder or call and leave a message regarding your appointment. We may review how your treatment was paid so that we can decide whether to continue providing a specific service. We may tell your health insurance company of a medical condition you have so that they can contact you regarding programs offered that will be beneficial to your care, such as weight loss, injury prevention or diabetic education programs.

Please notify us in writing at the address above, if you do not wish us to share information with your health plan so they can contact you regarding programs they may offer.

**Special Situations:**

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

- To avert a serious threat to health or safety, or a threat to the health and safety of the public or another person.
- As required by federal, state or local law.
- To military, veterans, national security and intelligence if required by military command or other government authorities.
- To worker's compensation carriers or programs relating to a work injury or illness.
- Public Health risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury to

PRIVACY POLICY (CONT.)

disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

- Health Oversight Activities: For audits, investigations, inspections or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- Lawsuits or disputes: If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
- Coroners, Medical Examiners, and Funeral Directors: We may release health information to a coroner or medical examiner as necessary. For example, to identify a deceased person or to determine the cause of death.
- Information not personally identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

**Family and Friends:** We may disclose health information about you to a family member if you are physically present and ask us to do so. For example, if you bring a family member or friend into an exam room, we will assume your permission to talk to you or that person regarding your health and care needs. Under most circumstances, we will not disclose your health information to a friend or family member unless you are present and agree to the disclosure. If you desire us to communicate with a friend or family member about your health in your absence, we will require written permission from you. However, if someone brings you to our facility for medical care and you are unable to communicate, we will keep that person informed of your status and progress. We will also use our professional judgment to make reasonable assumptions about sharing information with persons acting on your behalf, for example to pick up prescriptions or medical care equipment.

*Other Uses and Disclosures of Health Information*

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. We must obtain your Authorization to disclose information about you that is not related to treatment, payment or healthcare operations. We will require you to fill out our Authorization to Release Information Form, listing specific information you want released and to whom. You may revoke the authorization at any time, in writing, but we cannot take back any uses or disclosures that were already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information, and the Authorization will comply with the law governing HIV or substance abuse records.

In accordance with our document retention policy, all records may be destroyed if the patient has not been seen in our office in the past 10 years.

PRIVACY POLICY (CONT.)

**Your Rights Regarding Health Information About You.**

**You have the following rights regarding health information we maintain about you:**

**Right to Inspect and Copy:** You have the right to inspect and request a copy of your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our Privacy Officer in order to inspect a copy of your records. We will make requested and approved copies for you, and we will charge you for those copies at the *going* rate of our copying service. We will charge additionally for mailing copies for you. We will provide the copies within 14 calendar days. We may deny your request to inspect and receive a copy of your health information in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare provider to review your request and our denial. The person conducting the review will not be the same person who denied your request, and we will comply with the outcome of the review.

**Right to Amend:** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have a right to submit a written request for an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Records Amendment/Correction Form to our Privacy Officer at the address listed above.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

1. We did not create.
2. Is not part of the health information we keep.
3. You would not be permitted to inspect and copy.
4. Is accurate and complete.

**Right to an Accounting of Disclosures:** You have the right to submit a written request for an accounting of disclosures. This is a list of the disclosures we have made of medical information about you for purposes other than treatment, payment or operations, and not including disclosures for which we have your signed authorization. To obtain this list, you must submit your request in writing to our Privacy Officer. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The list will be provided in written format. The first list you request within a 12-month period will be provided at no cost. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions:** You have the right to submit a written request for a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. It is our policy that we do not share

**PRIVACY POLICY (CONT.)**

information about you unnecessarily with family or friends unless you have requested that. However, you additionally have the right to submit a written request for a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your written request unless the information is needed to provide emergency treatment to you.

**Right to Request Confidential Communications:** You have the right to submit a written request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we only contact you by mail instead of by phone. To request confidential communications, you must complete and submit the Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication Form to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of this Notice:** We are required to give you a copy of this Privacy Policy. By initialing our form in your chart, you are affirming that you did receive a copy. A copy of our Privacy Policy is available to any patient upon request.

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. You have a right to submit a written request for and receive a copy of any revised or changed notices.

*Complaints*

If you believe your privacy rights have been violated, you may file a written 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 at the address above. You will not be penalized for filing a complaint.