SOAPP® Version 1.0 – SF

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opiods for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1.	How often do you have mood swings?	0	1	2	3	4
2.	How often do you smoke a cigarette within an hour after you wake up?	0	1	2	3	4
3.	How often have you taken medication other than the way that it was prescribed?	0	1	2	3	4
4.	How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0	1	2	3	4
5.	How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4

Please include any additional information you wish about the above answers. Thank you.

PLEASE SEE REVERSE SIDE

©2015 Inflexxion, Inc. Permission granted solely for use in published format by individual practitioners in clinical practice. No other uses or alterations are authorized or permitted by copyright holder. Permissions questions: PainEDU@inflexxion.com. An online version of this tool is included in PainCAS. The SOAPP® was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

Date: _____

Name: _____

Opioid Risk Tool

		Mark each box that applies	*Office Use Only:* *Item Score if Female*	*Item Score if Male*
1. Family History of Substance Abuse	Alcohol	[ ]	*1*	*3*
	Illegal Drugs	[ ]	*2*	*3*
	Prescription Drugs	[ ]	*4*	*4*
2. Personal History of Substance Abuse	Alcohol	[ ]	*3*	*3*
	Illegal Drugs	[ ]	*4*	*4*
	Prescription Drugs	[ ]	*5*	*5*
3. Age (Mark box if between16 – 45)		[ ]	*1*	*1*
4. History of Preadolescent Sexual Abuse		[ ]	*3*	*0*
5. Psychological Disease	Attention Deficit Disorder,	[ ]	2	2
	Obsessive Compulsive Disorder,	[ ]		
	Bipolar Disorder,	[ ]		
	Schizophrenia	[ ]		
	Depression	[ ]	*1*	*1*
	TOTAL		_____	_____

Total Score Risk Category
Low Risk 0 – 3
Moderate Risk 4 – 7
High Risk ≥ 8

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine.* 2005;6(6):432-442. Used with permission

ROCHESTER RHIO

Regional Health Information Organization

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

PROVIDER: ROCHESTER PAIN MANAGEMENT

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans attached to this form to obtain access to my medical records through the health information exchange organization called Rochester RHIO. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Rochester RHIO is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Rochester RHIO's website at www.RochesterRHIO.org.

My information may be accessed in the event of an emergency, unless I complete this form and check box #2, which states that I deny consent even in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **I GIVE CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access ALL of my electronic health information through Rochester RHIO to provide health care services (including emergency care).

☐ **I DENY CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access my electronic health information through Rochester RHIO for any purpose, ***even*** *in a medical emergency (except for minor patients).*

If I want to deny consent for all Provider Organizations and Health Plans participating in Rochester RHIO to access my electronic health information through Rochester RHIO, I may do so by visiting Rochester RHIO's website at www.RochesterRHIO.org or calling Rochester RHIO at 1-877-865-RHIO(7446).

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through Rochester RHIO and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
    - **Treatment Services.** Provide you with medical treatment and related services.
    - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
    - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
    - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization(s) and/or Health Plan(s) listed may access ALL of your electronic health information available through Rochester RHIO. This includes information created before and after the date this form is signed. Your health records may include clinical notes, discharge summaries, allergies, a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), treatments you have received, your diagnoses, and lists of medicines you have taken. These records may contain all of this information about sensitive health conditions, including but not limited to:
    - Alcohol or drug use problems
    - Birth control and abortion (family planning)
    - Genetic (inherited) diseases or tests
    - HIV/AIDS
    - Mental health conditions
    - Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from the named Provider Organization(s) or Rochester RHIO. You can obtain an updated list at any time by checking Rochester RHIO's website at www.RochesterRHIO.org or by calling 1-877-865-RHIO(7446).

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one. If there is an emergency, doctors and other staff members will be able to use the Rochester RHIO to see the health information of patients who are minors.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Rochester RHIO for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization at: _____; or visit Rochester RHIO's website: www.RochesterRHIO.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as Rochester RHIO ceases operation (or until 50 years after your death whichever occurs first). If Rochester RHIO merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s). Organizations that access your health information through Rochester RHIO while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.

ROCHESTER PAIN MANAGEMENT

Restoring Life by Relieving Pain
585-248-9170

This consent allows Rochester Pain Management to use and disclose information about me protected under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Rochester Pain Management has provided me with access to a copy of their Privacy Notice bearing most recent effective date of April 9th, 2012. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing the consent.

I understand the terms of the Privacy Notice may change and that I may obtain revised notices.

I understand that I am responsible for any and all charges not covered by my insurance. I assign to Rochester Pain Management all rights and privileges and remedies to payment for health care services provided by Rochester Pain Management to which I am entitled.

I understand that if my insurance carrier does not send benefit payments directly to Rochester Pain Management and they are received by me, I am responsible to forward a copy of the Explanation of Benefits and make prompt payment to Rochester Pain Management.

Should my account be referred to a collection agency or an attorney, I shall be financially responsible to pay all collection and attorney fees. All delinquent accounts (those not paid within 30 days from the date of service or partial reimbursement of insurance of the insurance denial) may be sent to a collection agency.

I understand that Rochester Pain Management may refuse me for services if I refuse to sign this consent.

I understand I have the right to revoke the Privacy Notice Consent provided I do so in writing to the Privacy Officer, but that Rochester Pain Management may still use information to complete any actions prior to my revoking consent and which rely on my protected information.

Signature: _____ **Date:** _____

Print Name: _____

PLEASE SEE REVERSE SIDE

→

200 Linden Oaks Drive, Rochester, NY 14625
P: 585-248-9170 F: 585-248-9175

ROCHESTER PAIN MANAGEMENT

Restoring Life by Relieving Pain
585-248-9170

I, _____, give permission to all my health care and medical service providers to disclose and release my protect health information described below to:

Name(s): **Relationship:**

_____ _____

_____ _____

Health Information to be disclosed (Check all that apply):

- ☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)
  ~OR~
- ☐ My complete health record, as above, with the exception of the following information (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other – please specify: _____

    _____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons

This authorization shall be effective until (check one):

- ☐ All past, present, and future periods
  ~OR~
- ☐ Date or event: _____

  Unless I revoke it. (Note: You may revoke this authorization in writing at any time)

_____

Name of the Individual Giving this Authorization

_____ _____

Signature of the Individual Giving this Authorization Date

200 Linden Oaks Drive, Rochester, NY 14625
P: 585-248-9170 F: 585-248-9175

ROCHESTER PAIN MANAGEMENT

Restoring Life by Relieving Pain

200 Linden Oaks Drive, Suite 100, Rochester, New York 14625

(585) 248-9170 - Fax: (585) 248-9175

PATIENT FINANCIAL PAYMENT POLICY

The Patient Financial Payment Policy has been developed to help our patients understand their financial responsibilities related to their healthcare and to answer any questions regarding patient and insurance responsibility. If there are any questions regarding your health care benefits, you should contact your health plan with the phone number located on your insurance card.

We will keep a copy of your current insurance identification card(s) in your medical chart. **You** are responsible to notify us of any changes to your health plan coverage.

We accept cash, check or credit card for any payments required below.

Copayments The copay **must be** paid at the time of service.

Deductible Plans Until your annual deductible is met, we will collect the corresponding fee for the service being provided at the time of your appointment. Our billing office will send a claim to your Insurance Carrier which will document your payment. If, after the claim is processed, there is a balance you owe, you will be responsible to make a payment on account.

Non-participating Carriers You are responsible for full payment at the time of service. We will provide you with proper documentation for you to submit to your insurance carrier for reimbursement.

Self Pay Accounts/Un-insured You are responsible for full payment at the time of service.

Collection Process All past due accounts of 90 days or more, will be turned over to a collection agency. The additional fees associated with the collection agency will be the responsibility of the patient.

Workers Compensation You are responsible for providing the office with the necessary information at the time of service to submit the charges to your Workers Compensation carrier. If you do not provide the information, you will be responsible for the full payment.

No-Fault You are responsible for providing the office with the necessary information at the time of service to submit the charges to the No-Fault carrier and completing the appropriate assignment of benefits requirements. If you do not provide the information, you will be responsible for the full payment. Some No-Fault carriers have deductibles on medical charges for which the patient is responsible.

ROCHESTER PAIN MANAGEMENT

Restoring Life by Relieving Pain

200 Linden Oaks Drive, Suite 100, Rochester, New York 14625

(585) 248-9170 - Fax: (585) 248-9175

Patient Financial Payment Policy – Page 2

Missed Appointments If an appointment is missed or not cancelled within 48 business hours of the appointment, there will be a **$50.00** charge for each missed office appointment, and **$75.00** for each missed procedure appointment. Your insurance carrier WILL NOT pay a 'missed' appointment charge. You are responsible for any charges for missed appointments, and will have to pay before you can be rescheduled.

Returned Check Charges There will be a **$34.00** charge for each check returned to us.

Referrals If your insurance require referrals, it is your responsibility to make the office aware of this and verify that the referral is in place prior to the visit or you will be responsible for the visit.

If you have any questions on the Patient Financial Payment Policy, please ask to speak to Elsa Luzmila Zegarra at 585-248-9170 .

I _____ have read, understand and agree to the above policy.

Patient Name

_____ _____

Signature Date

ROCHESTER PAIN MANAGEMENT

Restoring Life by Relieving Pain
585-248-9170

Controlled Substance Agreement

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you. The long-term use of such substance as opioids (narcotic analgesics), benzodiazepine tranquillizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain. Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For these reasons the following policies are agreed to by you, the patient, as consideration for and a condition of the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. All controlled substances must come from the physician whose signature appears below, or during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment).
2. All controlled substance must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed.
3. You are expected to inform our office of any new medication or medical conditions, and of any adverse effects you experience from any of the medication that you take.
4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.
5. You may not share, sell, or otherwise permit others to have access to these medications.
6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.
8. Prescriptions and bottle of these medication may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.
9. Original containers of medications should be brought in to each office visit.
10. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
11. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.
12. Early refills will generally not be given.
13. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they are not to be filled prior to the appropriate date.
14. If the responsible legal authorities have questions concerning your treatment, as might occur, for example if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
15. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.
16. Renewals are contingent on keeping scheduled appointment. Please do not phone for prescriptions after hours or on weekends.
17. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.
18. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation).
19. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

_____ _____

Patient Signature Physician Signature

_____ _____

Patient Name (Printed) Date