

To my patients,

This is a very important message for you regarding **PAIN MEDICATIONS**. Please read the following document carefully and consider sharing this with your referring physician. You must agree to it and sign it. It will become a part of your permanent medical record.

*The medications used to manage pain are increasingly becoming a health issue and have been shown to lead to high rates of addiction, significant liver and kidney failure and even death. Because of these concerns I must limit the amount of medications I prescribe.*

No prescriptions will be written for you unless you have been:

- evaluated by Dr. Kwon & scheduled for surgery

**REFILLS:**

- Will be given up to **90 DAYS** (3 months) after surgery
- For **outpatient** surgery, you will get one prescription on the day of surgery and one at your 2-4 week follow-up
- Medication refill requests must occur **at least 3 days prior** to running out of medication
- Call in requests may not be handled on the same day and may take up to 3 business days. We will call in refills to only *one* pharmacy: **PLEASE INCLUDE INFORMATION BELOW**
- Refill requests made **after 1pm on FRIDAY** will be handled on the next business day
- Lost or stolen prescriptions will NOT be replaced
- Under no circumstances are patients allowed to pick up prescriptions at our office

We reserve the right to contact any of your current health providers if we suspect you may be abusing this policy.

Thank you for your understanding. By doing so, this policy allows us to direct our attention to our patients' more pressing needs.

Sincerely,

Brian Kwon, MD

**SIGNED:** \_\_\_\_\_

**PRINT NAME:** \_\_\_\_\_

**PHARMACY**  
**(name/city):** \_\_\_\_\_

**Ph#**

**Fax#** \_\_\_\_\_

**Brian Kwon, MD**

NAME \_\_\_\_\_ Sex M F  
Last First Middle

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

E-Mail \_\_\_\_\_

Primary Phone # \_\_\_\_\_ Alternate Phone #: \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Name Address Phone

Friend/Relative/Spouse \_\_\_\_\_ Phone \_\_\_\_\_

Referring Physician \_\_\_\_\_  
Name Phone  
Address \_\_\_\_\_ Fax # \_\_\_\_\_

Primary Care Physician \_\_\_\_\_  
Name Phone  
Address \_\_\_\_\_ Fax # \_\_\_\_\_

**Primary Insurance**

Name \_\_\_\_\_  
ID# \_\_\_\_\_  
Group# \_\_\_\_\_  
Subscriber \_\_\_\_\_  
SSN of Subscriber \_\_\_\_\_  
Ins. Address \_\_\_\_\_  
\_\_\_\_\_

**Secondary Insurance**

Name \_\_\_\_\_  
ID# \_\_\_\_\_  
Group# \_\_\_\_\_  
Subscriber \_\_\_\_\_  
SSN of Subscriber \_\_\_\_\_  
Ins. Address \_\_\_\_\_  
\_\_\_\_\_

**Workers' Compensation**

Insurance \_\_\_\_\_ Claim # \_\_\_\_\_  
Date of Injury \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Last Worked \_\_\_\_/\_\_\_\_/\_\_\_\_

Billing Address \_\_\_\_\_  
Adjuster \_\_\_\_\_ PH \_\_\_\_\_ FAX \_\_\_\_\_  
RN Manager \_\_\_\_\_ PH \_\_\_\_\_ FAX \_\_\_\_\_

Attorney \_\_\_\_\_  
Name Address Phone

I hereby assign to the physician for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance(s).

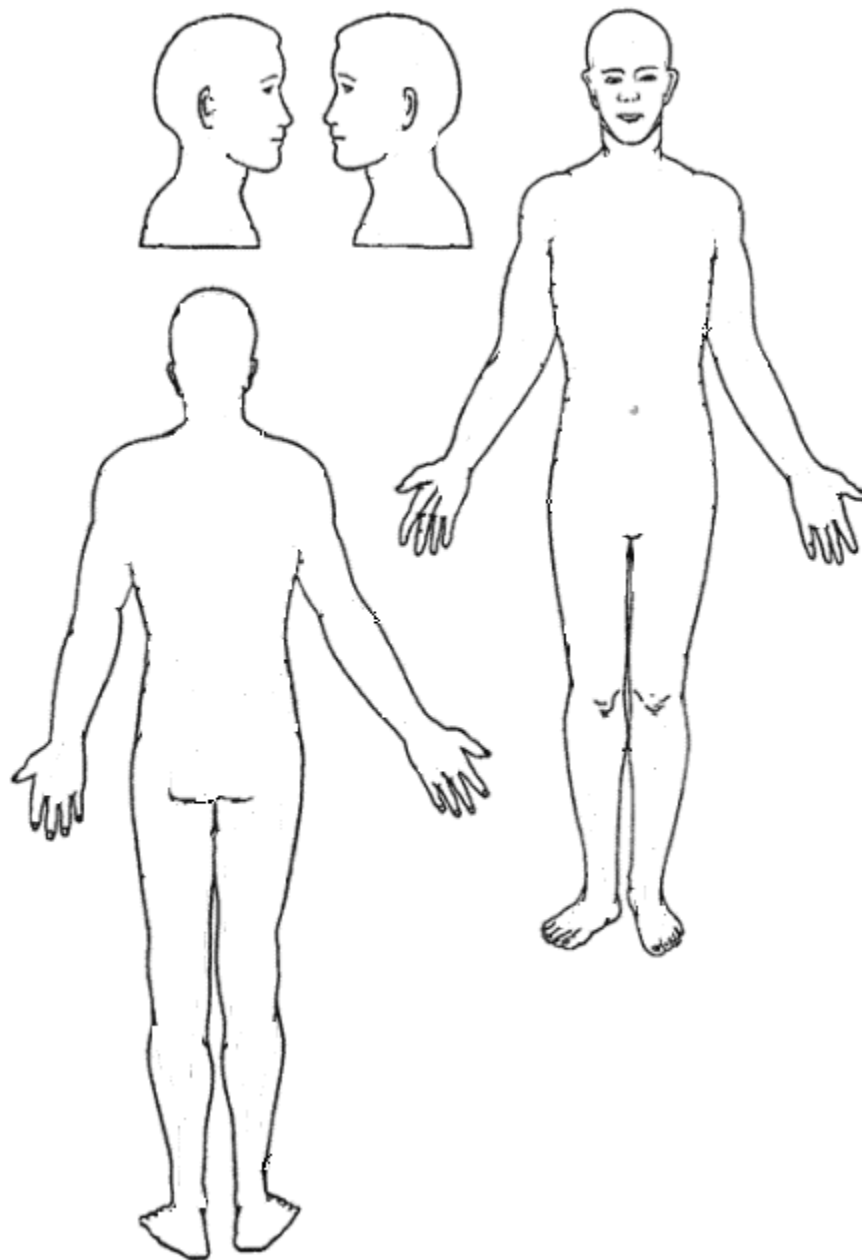
Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Using the symbols below, mark the area on your body where you feel:

.  
>>>> Numbness  
000000 Pins and Needles

XXX Burning  
!!!!!!! Stabbing

^^^^ Other Pain  
●●● Aching



How long have you had this pain? \_\_\_\_\_years \_\_\_\_\_months

What were you doing when it started? \_\_\_\_\_.

Does it feel BETTER when you are:

	YES	NO		YES	NO
Standing			Walking		
Sitting			Exercising		
Lying down			Other:		

Does it feel WORSE when you are:

	YES	NO		YES	NO
Coughing/sneezing			Bending		
Sleeping			Lifting		
Sitting			Walking		
Standing			Other:		

What kind of TREATMENT have you had for THIS CURRENT EPISODE of pain?

	YES	NO		
Bed rest			How many days?	
Medications			What kinds?	
Physical therapy			How many weeks?	Where?
Chiropractor				
Acupuncture				
Braces				
Injections (cortisone, steroids)			What kind (epidural, etc.)? Hospital?	
Other				

Have you had this problem before? Yes/No When? \_\_\_\_\_

Missed work because of this problem? Yes/No Last work day? \_\_\_\_\_

Were you involved in a work or motor vehicle accident? \_\_\_\_\_

Is there a lawyer involved? Yes/No Name \_\_\_\_\_

**Medical problems/Surgeries:** \_\_\_\_\_

<b>DIABETES? Y/N</b>	<b>HEART DISEASE? Y/N</b>	<b>INFECTIONS? Y/N</b>
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SPINE Surgeries \_\_\_\_\_

\_\_\_\_\_

When \_\_\_\_\_ Where \_\_\_\_\_ Surgeon \_\_\_\_\_

**MEDICATIONS** \_\_\_\_\_

**DRUG ALLERGIES** \_\_\_\_\_

Height: \_\_\_\_\_ ft \_\_\_\_\_ in      Weight: \_\_\_\_\_

**Smoke? YES / NO**      **Packs/day** \_\_\_\_\_      **# Years:** \_\_\_\_\_

Drink Alcohol? \_\_\_\_\_ **Drinks/wk:** \_\_\_\_\_

FAMILY MEMBERS with medical problems? (cancer, diabetes, etc.)

Relationship	Disease(s)
Father	
Mother	

**CIRCLE** the options below if you NOW have or RECENTLY had:

- |   |                               |                   |
|---|-------------------------------|-------------------|
| <b>Fever</b>                              | Palpitations                  | Bloody urine      |
| <b>Chills</b>                             | Heart skipping                | Menstrual changes |
| Excess sweating                           | High blood pressure           | Pain in joints    |
| Fatigue                                   | Swollen ankles/feet           | Decreased motion  |
| Insomnia                                  | Leg cramps                    | Muscle weakness   |
| Vision problems                           | <b>Shortness of breath</b>    | <b>Skin sores</b> |
| Eye pain                                  | Wheezing                      | Rashes/bumps      |
| <b>Headaches</b>                          | Cough                         | Jaundice          |
| Hearing loss                              | Sputum/bloody?                | Numbness          |
| Bloody nose                               | Heartburn                     | Tremor            |
| Mouth sores                               | Abdominal pain                | Fainting          |
| Throat Problems                           | Reflux                        | Nervousness       |
| <b>Significant weight loss (how much)</b> | <b>Change in bowel habits</b> | Depression        |
| Heart trouble                             | <b>Incontinence</b>           | Anxiety           |
| <b>Chest pain</b>                         | <b>Urinary frequency</b>      | Heat intolerance  |
| <b>Easy bruising</b>                      | <b>Excess bleeding</b>        | Excess thirst     |
| Swollen glands                            | Allergies                     | <b>Infections</b> |

For Women:

Pelvic/breast exams?	YES	NO	Last exam date
Abnormal results?	YES	NO	When?

Name: \_\_\_\_\_ Date \_\_\_\_\_

Date of surgery (if applicable) \_\_\_\_\_

Please indicate your level of NECK PAIN. Draw the symbols around: *worst* pain (highest number) with a triangle ( $\Delta$ ), *best* pain level (lowest number) with a square ( $\square$ ), *average* pain with a circle ( $\circ$ ).

**0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10**

Please indicate your level of ARM PAIN. Draw the symbols around: *worst* pain (highest number) with a triangle ( $\Delta$ ), *best* pain level (lowest number) with a square ( $\square$ ), *average* pain with a circle ( $\circ$ ).

**0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10**

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Please answer **every section**. Mark **one box only** in each section that most closely describes you **today**.

**1. Pain intensity**

- 0  I have no pain at the moment
- 1  The pain is very mild at the moment
- 2  The pain is moderate at the moment
- 3  The pain is fairly severe at the moment
- 4  The pain is severe at the moment
- 5  The pain is the worst imaginable at the moment

**2. Personal care** (washing, dressing, etc.)

- 0  I can look after myself normally w/o causing extra pain
- 1  I can look after myself normally but it is very painful
- 2  It is painful to look after myself and I am slow and careful
- 3  I need some help but manage most of my personal care
- 4  I need help everyday in most aspects of self care
- 5  I do not get dressed, wash with difficulty, and stay in bed

**3. Lifting**

- 0  I can lift heavy weights w/o extra pain
- 1  I can lift heavy weights but it gives extra pain
- 2  Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table
- 3  Pain prevents me from lifting heavy weights but I can manage light to medium weights
- 4  I can lift only very light weights
- 5  I cannot lift or carry anything at all

**4. Reading**

- 0  I can read as much as I want with no pain in my neck
- 1  I can read as much as I want with slight pain in my neck
- 2  I can read as much as I want with moderate pain in my neck
- 3  I can NOT read as much as I want because of moderate pain in my neck
- 4  I can hardly read at all because of severe pain in my neck
- 5  I cannot read at all

**5. Headaches** (in the past week)

- 0  I have no headaches at all
- 1  I have slight headaches which come infrequently
- 2  I have moderate headaches which come infrequently
- 3  I have slight headaches which come frequently
- 4  I have severe headaches which come frequently
- 5  I have headaches almost all of the time

Name: \_\_\_\_\_ Date \_\_\_\_\_

Date of surgery (if applicable) \_\_\_\_\_

**6. Concentration**

- 0  I can concentrate fully when I want with no difficulty
- 1  I can concentrate fully when I want with slight difficulty
- 2  I have a fair degree of difficulty in concentrating when I want to
- 3  I have a lot of difficulty in concentrating when I want to
- 4  I have a great deal of difficulty in concentrating when I want to
- 5  I cannot concentrate at all

**7. Work**

- 0  I can do as much work as I want to
- 1  I can only do my usual work, but no more
- 2  I can do most of my usual work, but no more
- 3  I cannot do most of my usual work
- 4  I can hardly do any work at all
- 5  I can't do any work at all

**8. Driving**

- 0  I can drive my car without any neck pain
- 1  I can drive my car as long as I want with slight pain in my neck
- 2  I can drive my car as long as I want with moderate pain in my neck
- 3  I can't drive my car as long as I want with moderate pain in my neck
- 4  I can hardly drive my car because of severe pain in my neck
- 5  I can't drive my car at all

**7. Sleeping**

- 0  I have no trouble sleeping
- 1  My sleep is slightly disturbed (less than 1 hour sleepless)
- 2  My sleep is mildly disturbed (1-2 hours sleepless)
- 3  My sleep is moderately disturbed (2-3 hours sleepless)
- 4  My sleep is greatly disturbed (3-5 hours sleepless)
- 5  My sleep is completely disturbed (5-7 hours sleepless)

**10. Recreation**

- 0  I can engage in all my recreational activities with no pain at all
- 1  I can engage in all my recreational activities with some pain in my neck
- 2  I can engage in most but not all my recreational activities because of pain in my neck
- 3  I can engage in few of my recreational activities because of pain in my neck
- 4  I can hardly do any recreational activities because of pain in my neck
- 5  I can't do any recreational activities at all

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What is your current work status? (circle)

Full-time                  Part-time                  Disabled                  Retired                  Student

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If you have had any treatment, (eg. surgery) would you say you are, in general: (circle)

Much Better                  Better                  Same                  Worse

## NOTICE OF PRIVACY 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.**

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example would include a physical examination or pertinent ancillary test results.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be a quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about other benefits or services that may be of interest to you. We may leave messages at your home with a family member, personal representative, or on your answering machine regarding appointment dates or instructions for care.

We may discuss medications, pre and post operative treatment, and instructions for care, with a family member or other personal representative.

We may share your protected health information with a representative of an implant manufacturer or distributor.

Any other uses or disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree with a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

Brian Kwon, MD  
125 Parker Hill Ave  
Boston, MA 02120



- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to request amendments to your protected health information.
- The right to receive an accounting of disclosures of protected health information upon request.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 15, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of privacy practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our privacy officer, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

**For information about HIPAA or to file a complaint:**

**The U.S. Department of Health and Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(202) 619-0257  
Toll Free: (877) 696-6775**

Brian Kwon, MD  
125 Parker Hill Ave  
Boston, MA 02120

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers, or as a result of a liability or worker's compensation claim.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

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### OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Brian Kwon, MD  
125 Parker Hill Ave  
Boston, MA 02120