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

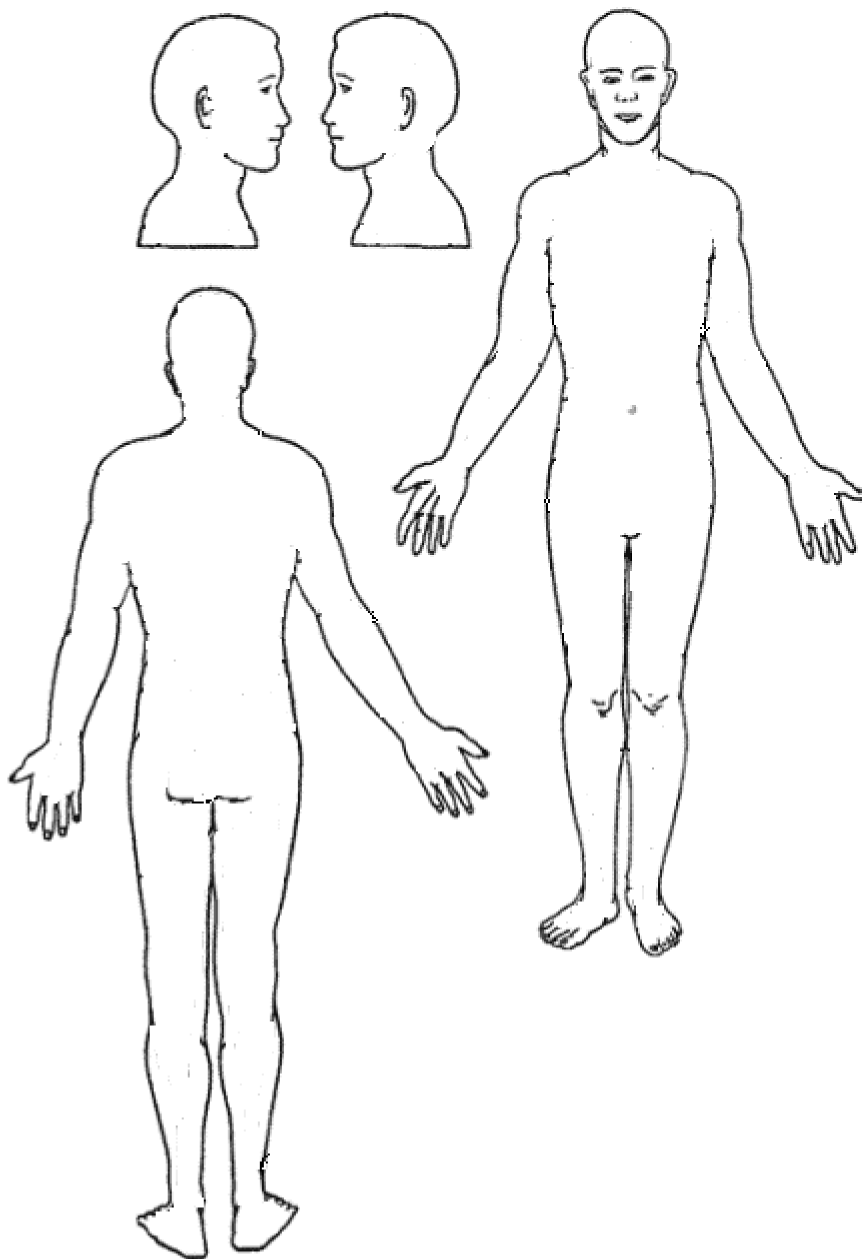
000000 Pins and Needles

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: ____

DIABETES? Y/N	**HEART DISEASE? Y/N**	INFECTIONS? Y/N

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:

Fever
Chills
Excess sweating
Fatigue
Insomnia
Vision problems
Eye pain
Headaches
Hearing loss
Bloody nose
Mouth sores
Throat Problems
Significant weight loss (how much)
Heart trouble
Chest pain
Easy bruising
Swollen glands

Palpitations
Heart skipping
High blood pressure
Swollen ankles/feet
Leg cramps
Shortness of breath
Wheezing
Cough
Sputum/bloody?
Heartburn
Abdominal pain
Reflux
Change in bowel habits
Incontinence
Urinary frequency
Excess bleeding
Allergies

Bloody urine
Menstrual changes
Pain in joints
Decreased motion
Muscle weakness
Skin sores
Rashes/bumps
Jaundice
Numbness
Tremor
Fainting
Nervousness
Depression
Anxiety
Heat intolerance
Excess thirst
Infections

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 BACK PAIN. Draw the symbols around: *worst* pain (highest number) with a triangle (Δ), *best* pain level (lowest number) with a square (□), *average* pain with a circle (o).

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

Please indicate your level of LEG PAIN. Draw the symbols around: *worst* pain (highest number) with a triangle (Δ), *best* pain level (lowest number) with a square (□), *average* pain with a circle (o).

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

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. Walking

0 __Pain does not prevent me walking any distance
1 __Pain prevents me walking more than 1 mile
2 __Pain prevents me walking more than ½ of a mile
3 __Pain prevents me walking more than 100 yards
4 __I can only walk using a stick or crutches
5 __I am in bed most of the time and have to crawl to the toilet

5. Sitting

0 __I can sit in a chair as long as I like
1 __I can sit in my favorite chair as long as I like
2 __Pain prevents me from sitting more than 1 hour
3 __Pain prevents me from sitting more than ½ of an hour
4 __Pain prevents me from sitting more than 10 minutes
5 __Pain prevents me from sitting at all

Name: ____ Date_______________
Date of surgery (if applicable)____________________

6. Standing

0 __I can stand as long as I want w/o extra pain
1 __I can stand as long as I want but it gives extra pain
2 __Pain prevents me from standing more than 1 hour
3 __Pain prevents me from standing more than ½ of an hour
4 __Pain prevents me from standing more than 10 minutes
5 __Pain prevents me from standing at all

7. Sleeping

0 __My sleep is never disturbed by pain
1 __My sleep is occasionally disturbed by pain
2 __Because of pain I have less than 6 hours of sleep
3 __Because of pain I have less than 4 hours of sleep
4 __Because of pain I have less than 2 hours of sleep
5 __Pain prevents me from sleeping at all

8. Sex life (if applicable)

0 __My sex life is normal and causes no extra pain
1 __My sex life is normal but causes some extra pain
2 __My sex life is nearly normal but is very painful
3 __My sex life is severely restricted by pain
4 __My sex life is nearly absent because of pain
5 __Pain prevents any sex life at all

9. Social life

0 __My social life is normal and causes no extra pain
1 __My social life is normal but increases the degree of pain
2 __Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports, etc.
3 __Pain has restricted my social life and I do not go out as often
4 __Pain has restricted my social life to my home
5 __I have no social life because of pain

10. Traveling

0 __I can travel anywhere w/o pain
1 __I can travel anywhere but it gives extra pain
2 __Pain is bad but I manage journeys over 2 hours
3 __Pain restricts me to journeys of less than 1 hour
4 __Pain restricts me to short necessary journeys under 30 minutes
5 __Pain prevents me from traveling except to receive treatment

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What is your current work status? (circle)

Full-time Part-time Disabled Retired Student

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.

- 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

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: ____

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:	Initals:	Reason:

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