NEW PATIENT INFORMATION RECORD

Failure to complete this entire form PRIOR to your appointment may result in rescheduling. This information is kept confidential and will be available to your health care team.

PLEASE BRING THIS COMPLETED FORM WITH YOU ON YOUR NEXT VISIT

Today's Date:_____/_____/_____

Last Name:_____ First:_____ MI:_____

Date of Birth:_____/_____/_____ Sex:_____ Age:_____

Home Phone: ( )_____ Mobile Phone: ( )_____

Address:_____ City:_____ State:_____ Zip:_____

E-mail :_____ Race_____ Ethnicity_____ Language_____

Marital Status:_____ Spouse's Name:_____

Referring Physician: _____ Telephone: ( )_____

Primary Care Physician: _____ Telephone: ( )_____

PRIMARY INSURANCE

Insurance Company:_____ Policy Holder's Name:_____

Policy Holder's DOB:_____/_____/_____ Relationship to Patient:_____

Policy #_____ Group #:_____ Benefits #_____

Policy Holder's Employer:_____

SECONDARY INSURANCE

Insurance Company:_____ Policy Holder's Name:_____

Policy Holder's DOB:_____/_____/_____ Relationship to Patient:_____

Policy #_____ Group #:_____ Benefits #_____

Policy Holder's Employer:_____

EMERGENCY CONTACT

Name:_____ Relationship:_____ Phone: ( )_____

PHARMACY INFORMATION

Pharmacy _____ Location_____

Phone _____

PRIOR TREATMENT

Below are listed different medical specialties. Indicate if you have seen any of these specialists ***for your pain condition.*** [Please fill in names that apply]

Specialty	Doctor's Name	Specialty	Doctor's Name
Cardiologist [Heart]	_____	Orthopedic Surgeon [Bones]	_____
Chiropractor	_____	Pain Specialist	_____
General/Family Practice	_____	Physiatrist [Rehab]	_____
Internal Medicine [Internist]	_____	Physical Therapy *Therapist:*	_____
Neurologist [Nervous System]	_____	*Facility:*	_____
Neurosurgeon	_____	Number of emergency room visits	_____

Have you ever been a patient in a pain clinic before? Yes or No If yes, complete the chart below. If a pain practice or provider is not listed please add their information at the bottom of the chart.

Clinic and/or Provider Name	How Long Were You A Patient?	Were you Discharged? Yes or No	Reason You Were Discharged
Carolyn Davis/Carolina Pain and Weight Loss			
Dr. Edmiston			
Dr. Goodson			
PHC-Govil Spine and Pain Care			
Dr. Hansen/Pain Relief Centers			
Dr. Mark Hines			
Dr. Laguerre/ LKN Anesthesia			
Dr. Pritchard			
Dr. Watson			
Dr. Wilson			
Northeast Pain			
Pain MD			
Revival Pain Clinic			
Southeast Pain			
Unifour Pain			

WHY ARE YOU HERE? (Chief Complaint)

What is the main problem for which you are seeking treatment at Lake Norman Pain and Weight Management, LLC for pain relief? _____

MEDICATIONS

(Prescribed medications that you are **currently taking**)

Name of Drug	Strength	# of Times Taken Per Day	Prescribing Provider
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES

Do you have any drug allergies that you are aware of? ___Yes ___No / Are you allergic to any shellfish? ___Yes ___No

Item	**Reaction**	**Item**	**Reaction**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Substance Abuse

Do you have a history of:

Tobacco use? ___Yes-Currently ___Yes- In the past ___Never

Alcohol use? ___Yes (Drinks per day_____) ___Yes- In the past ___Never

Illicit (Illegal) Drug use? ___Yes-Currently ___Yes- In the past ___Never

Have you ever been convicted of a felony? Yes_____ No_____ If yes, please explain below.

_____

Approximately how many times have you been to the emergency room over the past year due to pain?

___none ___less than 5 times ___ 6-10 times ___more than 10 times

Have you ever been in a Detoxification Program for Drug Abuse? _____Yes _____No If yes, when?

_____

Have you ever been prescribed Suboxone or Subutex? Yes_____ No_____ If yes, please explain

_____

Have you ever been treated in a Methadone Clinic? Yes_____ No_____ If yes, please explain

_____

What have you taken for pain over the past 2-3 days?

_____

PAST MEDICAL HISTORY

Have you had any of the following health problems? (check all that apply)

___Angina or Chest Pain	___Chronic Cough	___Kidney Disease	___Seizure or Epilepsy
___Arthritis	___Diabetes	___Liver Disease	___Thyroid Disease
___Asthma or Wheezing	___Heart Attack	___Peptic Ulcer	___ Stroke
___Bleeding Problems	___High Blood Pressure	___Reflux (GERD)	___Treatment for Addiction

___Cancer: What Type _____

Note: If you checked yes to any of the above questions, please give an explanation: _____

SURGICAL HISTORY

Name of Surgery	Where Performed	When	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

GENERAL FAMILY HISTORY

Please indicate the following regarding your family:

	Status	Year of Birth (if known)
Mother	_____ Alive ____Deceased	
Father	_____ Alive ____Deceased	
Paternal Grandmother [Father's Side]	_____ Alive ____Deceased	
Maternal Grandmother [Mother's Side]	_____ Alive ____Deceased	
Paternal Grandfather [Father's Side]	_____ Alive ____Deceased	
Maternal Grandfather [Mother's Side]	_____ Alive ____Deceased	
Are any of your siblings deceased?	____No ____Yes, specify cause of death: _____	

Review the list below and use the scale below to indicate the person in your family who has had the disease or illness.

M= Mother F= Father PGM= Paternal Grandmother MGM= Maternal Grandmother
PGF= Paternal Grandfather MGF= Maternal Grandfather S= Siblings C=Children

_____Angina or Chest Pain	_____ Chronic Cough	_____ Kidney Disease	_____ Seizure or Epilepsy
_____ Arthritis	_____ Diabetes	_____ Liver Disease	_____Thyroid Disease
_____Asthma	_____ Heart Attack	_____ Peptic Ulcer	_____Reflux (GERD)
_____ Bleeding Problems	_____ High Blood Pressure	_____ Addiction	_____ Stroke
_____ Cancer: What Type	_____	_____	_____
_____ Other:	_____	_____	_____

Does any member of your family have problems with drugs or alcohol? ___Yes ___No if yes, please specify:

_____

Does any member of your immediate family have a chronic pain condition? ___Yes ___No if yes, please specify:

SOCIAL HISTORY

Marital Status

___Divorced ___Remarried ___Spouse Deceased

___Engaged ___Separated ___Significant other Deceased

___Married Living w/Spouse ___Single

Living Arrangements

___Living Alone ___Living with Children ___Living with Spouse/Partner and Children

___Living with Friends ___Living with Spouse/Partner ___Living with Other

EMPLOYMENT

What is/Was your Occupation? _____

Current employment status (please check all that apply):

___Employed full-time ___Unemployed

___Employed part-time ___Retired

___Student ___Homemaker

___Unemployed or Working Part Time because of pain ___Disability

If unemployed, indicate how long you have been out of work?

_____

Please indicate any of the following claims you have related to your pain problem:

___Workers' compensation ___Other Insurance

___Person injury/liability (unrelated to work) ___None

___Social Security Disability Insurance (SSDI)

Psychological Treatment

Have you ever had psychiatric, psychological, or social work evaluation/treatments for any problem, including your pain?

_____Yes _____No If yes, when? _____

Have you ever considered suicide? _____Yes _____No If yes, when? _____

Have you ever attempted suicide? _____Yes _____No If yes, how? _____

Are you currently in counseling or therapy? _____Yes _____No If yes, Name & date of last Visit __ _____

Onset of pain (Cause)

How did your current pain start?

_____ Injury at Work _____ Motor Vehicle Accident

_____ Injury, Not at Work _____ Illness

_____ Treatment Caused (e.g., radiation, surgery, etc.) _____ Undetermined

_____ Other _____

When did your pain begin? _____

HISTORY OF PRESENT ILLNESS

What part(s) of your body hurts?

___Neck ___Low Back ___Mid Back ___Leg L / R ___Shoulder L / R ___Arm L / R ___Hip L / R

___Knee L / R ___ Foot L / R ___Big Toe ___Little Toe ___Hand ___Thumb ___Finger

If multiple areas of pain, what is the worst area? _____

My pain is described as:

___Dull ___Achy ___Throbbing ___Sharp ___Burning ___Constant

___Numbness ___Tingling ___Stabbing ___Weakness ___Stiffness

Does your pain radiate, shoot, or travel? ___Yes ___ No If yes

- **Radiates FROM my:**

___Neck ___Low Back ___Mid Back ___Abdomen ___Elbow ___Wrist

- **And STOPS at my:**

___ Upper Arm ___Elbow ___Wrist ___Fingers ___Hip ___Knee ___Shin ___Ankle ___Foot ___Toes

My Pain Causes:

___Decreased ability to function ___Anger ____Anxiety ___ Depression ___Blurred Vision ___Change in appetite

___Fatigue ___Headache ___Loss of bladder/bowel function ___Movements at night ____Sleeping Problems

___Difficulty with sexual relations ___Sleep Apnea ____Weakness ____Weight gain ___Nausea ___Other

My Pain Is Worse With:

____Walking ____Bending ____Sitting ____Standing ____Work ____Physical Therapy ____Shopping/Yard Work

____Household Chores ____Activity ____Cold/Cold Weather ____Lifting ____Looking Up/Down/Around

____Movement ____Position Changes ____Coughing/Sneezing ____Driving ____Touch ___Other

My pain is improved with: ___Rest ___Heat/Ice ___Medications ___Exercise ___Phy. Therapy

___Epidural Injections/Nerve blocks ___Other _____

Please rate the following ***WITHOUT*** Pain Medication: **[0]=No Pain [10]=Most Severe Pain**

Maximum Pain Level (Circle one)**:** 0 1 2 3 4 5 6 7 8 9 10

Minimum Pain Level (Circle one)**:** 0 1 2 3 4 5 6 7 8 9 10

Average Pain Level (Circle one)**:** 0 1 2 3 4 5 6 7 8 9 10

Please rate the following ***WITH*** Pain Medication: **[0] =No Pain [10] =Most Severe Pain**

Maximum Pain Level (Circle one)**:** 0 1 2 3 4 5 6 7 8 9 10

Minimum Pain Level (Circle one)**:** 0 1 2 3 4 5 6 7 8 9 10

Average Pain Level (Circle one)**:** 0 1 2 3 4 5 6 7 8 9 10

Do you use Ibuprofen, Aleve, Goody Powders, Aspirin, Tylenol, Advil or Mobic?

___No ___Yes, Amount per day: _____

Attempted Treatments: Please check all treatments you have and then complete the follow column at the right.

Treatment	Date (approximate)	No Relief	Moderate Relief	Excellent Relief
___Acupuncture	_____	☐	☐	☐
___Bedrest	_____	☐	☐	☐
___Exercise	_____	☐	☐	☐
___Physical Therapy	_____	☐	☐	☐
___Heat	_____	☐	☐	☐
___Ice	_____	☐	☐	☐
___Psychotherapy	_____	☐	☐	☐
___Chiropractic	_____	☐	☐	☐
___Back Brace	_____	☐	☐	☐

Treatment	Date (approximate)	No Relief	Moderate Relief	Excellent Relief
__Steroid Injections Or Joint injections	_____	☐	☐	☐
___Facet Injections	_____	☐	☐	☐
___Radio Frequency Ablation	_____	☐	☐	☐
___Nerve Block or Other	_____	☐	☐	☐
___Surgery	_____	☐	☐	☐

Treatment	Date (approximate)	No Relief	Moderate Relief	Excellent Relief
___Spinal Cord Stimulator	_____	☐	☐	☐
___Botox	_____	☐	☐	☐
___Trigger Points	_____	☐	☐	☐

History of Medications: Fill out the chart below for any medications you have used in the past or are currently using.

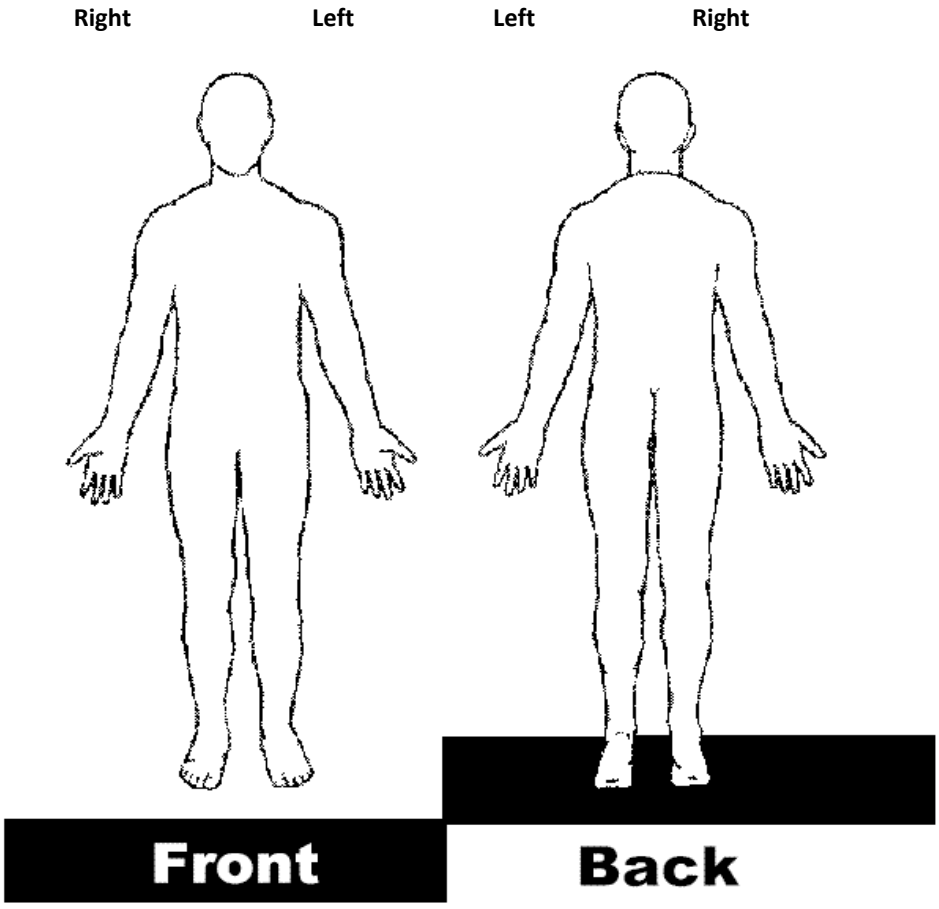
Medication	Side Effects	Did it work?	Medication	Side Effects	Did it Work?
Hydrocodone • Lorcet • Lortab • Norco • Vicodin • Hysingla	YES NO	YES NO	Codeine/APAP • Tylenol w/Codeine Nucynta Levorphanol	YES NO YES NO YES NO	YES NO YES NO YES NO
Oxycodone: • Roxicodone • Percocet • Endocet • Tylox • Percodan • OxyContin • Xartemis	YES NO	YES NO	Buprenorphine • Subutex • Suboxone • Butrans • Belbuca Tramadol • Ultram • Ultracet	YES NO YES NO	YES NO YES NO
Hydromorphone • Dilaudid • Exalgo	YES NO	YES NO	Alprazolam • Xanax Clonazepam • Klonopin	YES NO YES NO	YES NO YES NO
Morphine • MS Contin • Avinza • Kadian • MSIR • Embeda	YES NO	YES NO	Diazepam • Valium Lorazepam • Ativan	YES NO YES NO	YES NO YES NO
Methadone • Dolophine • Methadose	YES NO	YES NO	Carisoprodol • Soma	YES NO	YES NO
Meperidine • Demerol	YES NO	YES NO	Cyclobenzaprine • Flexeril	YES NO	YES NO
Oxymorphone • Opana IR • Opana ER	YES NO	YES NO	Tizanidine • Zanaflex Baclofen	YES NO YES NO	YES NO YES NO
Fentanyl • Duragesic Patch • Fentora • Actiq • Subsys	YES NO	YES NO	Zolpidem Tartrate • Ambien • Ambien CR	YES NO	YES NO
			Neuropathic Pain & Fibromyalgia • Gabapentin • Gralise • Lyica • Cymbalta	 YES NO YES NO YES NO YES NO	 YES NO YES NO YES NO YES NO

DIAGNOSTIC STUDIES

Indicate which of the following studies/tests you have had to work-up your **current pain problem:**

Type of Study	Check all that apply	**Where performed**	**Approximate date**
MRI	_____	_____	_____
CT Scan	_____	_____	_____
Myelogram	_____	_____	_____
EMG/Nerve Study	_____	_____	_____
Plain X-rays	_____	_____	_____
Bone Scan	_____	_____	_____
Sleep Study	_____	_____	_____
Other:	_____	_____	_____

Color in the areas where you experience pain



Review of Systems

Please mark all items that apply to you:

Constitutional

__Recent Change in Weight
Gain_____lb.
Loss_____lb.

Eyes/Ears/Nose/Throat

__Blurring Vision

Cardiovascular

__High Blood Pressure
__Chest Pain
__Frequently Take
Aspirin/Blood Thinner

Respiratory

__Wheezing
__Shortness of Breath

Gastrointestinal

__Change in Bowel Habit
__Heartburn
__Diarrhea
__Blood in Stool
__Constipation
__Nausea/Vomiting

Genitourinary

__Kidney Trouble
__Frequent/Painful Urination
__Blood in Urine

Neurological

__Headaches
__Seizures

Psychiatric

__Excessive Worry
__Depression
__Bipolar Disorder
__Memory Loss
__Psychiatric Hospitalization
__Other Psychiatric Diagnosis

Hematological

__HIV Positive

OPIOID USE AGREEMENT

Opioid (narcotic pain killers) have side effects that can be harmful if taken inappropriately and without close monitoring. It is the responsibility of the providers at Lake Norman Pain and Weight Management, PLLC (LNPWM) to inform you of the risks and to enact procedures to ensure your safety on these medications. In order to continue receiving prescriptions from LNPWM, I agree to abide by the following set of conditions representing or contracted by LNPWM:

1. I do not have a current problem with drug dependence or substance abuse. I do not use illegal or illicit drugs.
2. I have disclosed to the pain provider treating me of any history (past or present) of alcohol and/or controlled substance abuse. I have disclosed to the pain provider treating me of any personal history and current activities involving the use, sale or possession of controlled substances. Controlled substances include prescription and non-prescription drugs (e.g. marijuana, cocaine, etc.).
3. I agree that other reasonable forms of treatment have not been effective or have produced too many side effects.
4. **I agree to obtain all prescriptions for opioids from LNPWM and to only take medication that is prescribed to me.** I will inform other physicians/providers who provide my care of this agreement. **I will not accept, fill, or use pain medication prescribed by another provider unless I have notified LNPWM and received permission to do so.**
5. I agree to take medicines only as prescribed by the pain providers. I understand that taking extra medication can cause me to become overly sedated and is dangerous. I understand that taking extra medication will also cause me to run short or run out of medication before my refill or next appointment. I agree to contact the office to schedule an appointment if I feel that the medication is not controlling my pain.
6. **I agree to bring medication bottle(s) for medications prescribed by LNPWM to *each and every visit*. I understand that my prescription is written for a 30 day supply and that my appointment is often in less than 30 days. I understand I must bring all remaining medication in the original medication bottle. Empty medication bottles should be brought to the visit as well. I understand that if I don't bring the medication bottles, I may be required to go home to get the bottle(s).**
7. **I understand that I may be called in for random pill counts, which means I must have a working phone number to receive these calls. If I am notified that a random pill count is required, it is my responsibility to report to the office or follow other instructions by staff to have my pills counted by the end of the business day. IT IS MY RESPONSIBILITY TO NOTIFY LNPWM OF ANY CHANGE IN MY PHONE NUMBER. If my contact information on record is incorrect or fail to comply with the pill count I may be discharged from the practice**.
8. I will submit to random drug screens (urine specimen or oral swabs) or urine tests in order to assess the effect of the narcotics and my compliance with treatment.
9. All medication prescribed by LNPWM must be accounted for. I agree that I will **not destroy or throw away any narcotics medications.** I understand that before a new narcotic prescription is issued, I must return the medication to the office to be counted and destroyed by LNPWM staff.
10. I will not under any circumstances allow other individuals to take my medications. I will keep the medications safe from theft by storing the medications in a lock box or other safe storage device.
11. I agree to keep all my scheduled appointments with the pain provider. **I understand that if I do not keep my follow up appointments, I may run out of medication and that LNPWM will not prescribe medication until**

my next appointment. I will participate fully in other services recommended by the pain providers to include psychological, psychiatric or physical rehabilitation services deemed necessary by the pain physician.

12. I agree to allow LNPWM to communicate with my referring and primary physicians/providers as well as any pharmacists, pharmacies, and the NC Controlled Substance Reporting database regarding my use of controlled substances.
13. I agree to identify all physicians/providers that I have seen in the past two years as well as physicians/providers that I see while in treatment with LNPWM. These other physicians/providers will be authorized by me to provide information to the pain physicians/providers with regard to my treatment with them.
14. I will follow the advice of LNPWM with regard to stopping controlled substances should the providers feel it is advisable.
15. If a female of childbearing age, I certify that I am not pregnant and that I will take measures to prevent pregnancy during the course of my treatment with opioids. If I become pregnant, I will inform the pain providers immediately.
16. A return to some type of gainful employment or other physical activities may need to be documented and the continued use of long-term narcotics through this clinic may be contingent on such improvement.
17. **I understand that I am responsible for my medications and that no allowance (police report or not) will be made for lost prescriptions or medications. Prescriptions will not be refilled early under any circumstances.**
18. I understand that on nights, holidays or weekends additional narcotic pain medications will not be refilled. I understand that after hours the providers do not have access to my chart to verify my statements. I must call during business hours. **I understand that if I choose to go to the Emergency Room to have my pain treated after hours, I am not to accept a prescription from the ER providers and must call the office during office hours the following business day to notify my provider of the reason for the ER visit and to discuss further treatment options.**
19. I under that Lake Norman Pain and Weight Management, PLLC may stop this mode of treatment if this contract is violated by me. Also Lake Norman Pain and Weight Management, PLLC for other reasons may stop this mode of treatment if deemed not safe to continue.
20. I understand that if Lake Norman Pain and Weight Management, PLLC initiates withdrawal of these medications, the providers may choose to send me elsewhere if they feel a dependency issue has arisen. Lake Norman Pain and Weight Management, PLLC reserves the right to require a “drug holiday” to keep the tolerance to the medication down.
21. I agree to have all my prescriptions filled at the same pharmacy and to inform the pain provider of changes in the designated pharmacy.
22. **I understand that disciplinary sanction includes but is not limited to: oral/written warning, counseling, restriction, and/or expulsion from clinic without referral, referral to police or state bureau of investigation for prosecution, immediate discontinuation of medication without substitution**.
23. **I understand that Lake Norman Pain & Weight Management, PLLC may notify authorities, referring physicians, pharmacies and other deemed necessary for violation of this contract**.

I have read this document and understand it fully. I have had all my questions answered satisfactorily. I fully intend to abide by the conditions set for by Lake Norman Pain and Weight Management, PLLC for the administration of opioid therapy. I understand and have read the potential risks and benefits of opioid therapy. I consent to the use of opioids to help control my pain. I understand that my treatment with opioids will be carried out in accordance with the conditions stated above.

Patient’s Signature: _____ Date: _____

Patient’s Name (Print): _____

Policies and Procedures

Please initial on each line, indicating your understanding of the policies and procedures for Lake Norman Pain and Weight Management, PLLC [LKNPWM].

____Our office sees patients by appointment only. I understand that if I am 10 minutes late for my appointment, it will be rescheduled for another date and/or time. I understand that I will not be given a prescription for medication if my appointment is rescheduled due to late arrival or missed appointments. I understand that I need to give 24 hours' notice to cancel or reschedule my visit. I understand that LKNPWM reserves the right to discharge me from the practice if I do not show for scheduled appointments 3 or more times.

____I authorize the release of medical records to my primary care or referring physician for treatment and coordination of care purposes and as necessary to process insurance claims, including claims for disability benefits, insurance applications and prescriptions. I authorize transmission of medical information by fax.

____I understand that LKNPWM has made the Notice of Privacy Practices available for my review in the lobby and on the website.

____ I acknowledge full financial responsibility for services rendered by LKNPWM regardless of insurance coverage and whether or not there was an accident with another party at fault.

____I understand that as of July 5, 2014, LKNPWM does not accept checks for services. LKNPWM accepts cash and all major credit and debit cards.

____ LKNPWM will file your insurance. I authorize my health insurance company to utilize my medical information as reasonably necessary for the proper administration of the health plan. I hereby assign LKNPWM any payments of medical benefits for services rendered to myself or dependents. **Co-payments: LKNPWM is required by your insurance to collect your co-payment. If you do not have your co-payment your appointment will be rescheduled.** I understand that it is my responsibility to notify LKNPWM of any changes in my insurance. I have read and understand that I am responsible for paying for the annual deductible, co-payment, coinsurance and any charges for non-covered services as determined by my insurance. I understand LKNPWM will scan copies of my insurance card into my file for reference, but this does not confirm your coverage is effective or that services rendered will be covered by your insurance. I currently have the following insurance plan(s)[check all that apply]:

☐Medicaid ☐Medicare ☐Supplemental Plan for Medicare ☐Other: _____

____ **Self-pay patients:** I understand that I must pay the cost of each visit prior to being seen. I understand that I am also responsible for the costs of any procedures done during my visit (ie drug screen, injections).

_____ __ _____

Signature Date

I have received and reviewed the Opioid Use Agreement. I have read the document and understand it fully. I have had all my questions answered satisfactorily. I fully intend to abide by the conditions set for by LKNPWM for pain management. I understand and have read the potential risks and benefits of pain management with medications. I consent to the use of opioids and other medications to help control my pain. I understand that my treatment with opioids and other medications will be carried out in accordance with the conditions stated in the agreement.

_____ _____

Signature Date

Authorization for Release of Information

Name of Patient: _____ DOB: _____

HIPAA regulations require that patients authorize the release of information to other individuals or facilities. Please complete the following information indicating what information we may release to whom.

Appointment Reminders

____ I authorize LNPWM to leave a brief message on the voicemail of my home and/or cell phone to remind me of upcoming appointments.

____ I authorize LNPWM to leave a brief message with individuals answering my home phone or cell phone to remind me of upcoming appointments.

Email Communication

____ I authorize LNPWM to email information to me at my request. I understand that if the email is not sent in an encrypted manner there is a risk that it could be accessed inappropriately. I still elect to receive email communication.

Please check boxes for the types of information that you may want emailed:

☐ Financial Information ☐ Appointment Reminder ☐ Breach Notification

☐ Other: _____

Other Information:

I authorize LNPWM to release information to the following individuals:

Name of Individual	Relationship	Phone Number	Information to be Released
			☐ Financial ☐ Treatment Plans ☐ Other
			☐ Financial ☐ Treatment Plans ☐ Other
			☐ Financial ☐ Treatment Plans ☐ Other
			☐ Financial ☐ Treatment Plans ☐ Other

Patient Rights:

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

Patient's Signature: _____ Date: _____

Patient's Name (Print): _____

LAKE NORMAN PAIN AND WEIGHT MANAGEMENT
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

The Covered Entity may use or disclose your protected health information ONLY for purposes of treatment, payment, health care

Part 1. INDIVIDUAL'S INFORMATION

Individual's Name:		Identification Number:	
Home Street Address:		Date of Birth:	
City:	State:	Zip Code:	Phone Number:

Part 2. INFORMATION ABOUT THE USE or DISCLOSURE

I, the undersigned individual, hereby voluntarily authorize the following Entity and its business associates to disclose information from my health record.

The information is to be disclosed by:	**And is to be provided to:**
Name of Facility:	Name of Person/Organization/Facility: **LAKE NORMAN PAIN & WEIGHT MANAGEMENT**
Address:	Address: **444 WILLIAMSON ROAD, SUITE D MOORESVILLE NC 28117**
City/State:	PHONE: **704-662-0009** FAX: **704-360-2335**

Purpose for Disclosure:

☐Further Medical Care ☐Personal Use ☐Disability ☐Attorney

☐Other *(specify)*_____

Information to be disclosed from my heath record:

☐Entire record ☐Diagnostic Reports [labs (including drug tests), x-ray, MRI, etc.] ☐Progress notes

☐Discharge Letter from Previous Pain Clinic

☐Only information related to (specify)_____

☐Only the period of events from _____ to _____.

☐Other *(specify)* _____

I understand and agree the following sensitive information will be disclosed if I place my **initials** in the applicable space next to the type of information.

_____ **Drug/alcohol diagnosis, treatment, or referral information** _____ **Genetic testing information**

_____ Mental health information _____ HIV/AIDS information

I understand that if this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration* event is specified. **Expiration Date/Event of Authorization**: _____

Part 3. IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

Part 4. SIGNATURE of INDIVIDUAL or REPRESENTATIVE

I hereby authorize the Entity and its business associates to use or disclose my protected health information as described in Part 2.

_____ Signature of individual or legal representative	_____ Date
_____ Printed name of individual's legal representative, if applicable	_____ Representative's relationship to individual

operations or other reasons permitted by law (please review the Entity's Notice of Privacy Practices for more information). You must authorize any other use or disclosure of your protected health information. You have the right to refuse this authorization.