To our patients… from Dr. James Patrick Murphy

Welcome to **Murphy Pain Center of Southern Indiana**.

We are honored you have chosen us. When you become a patient here, you become a partner with us. It will be a privilege to work with you. Murphy Pain Center exists for one reason-- to help you feel the best, perform the best, and be the best you can be.

Every pain management center is unique. Our approach at Murphy Pain Center is a combination of what I have learned from my pain fellowship at **the Mayo Clinic**, my residency training in Anesthesiology, Psychiatry, and Aerospace Medicine, my colleagues, and most importantly my patients. My promise to you is that we will strive to stay abreast of the latest technologies and philosophies in the ever-changing field of Pain Medicine. Furthermore, I promise that we will never forget that all of the science in the world does not mean anything unless it can actually help you get better.

We realize there are many factors that can contribute to one's pain, such as emotional, social, and economic concerns. We use many different diagnostic tools, consultants, and procedures to help us understand your pain. But most importantly we want to get to know you. Because just as every pain management center is unique, every person is unique.

Understanding that money and time restraints are often issues, we try to develop a program that works for you. We may offer you medications, office procedures, outpatient hospital procedures, surgeries, physical therapy, and even some "complementary" therapies such as smiles, and the occasional hug. **We want you to manage your pain instead of your pain managing you.**

We sometimes do prescribe narcotics and other controlled substances when medically necessary and other measures have failed. We therefore go to great lengths to make sure that if you truly need these medications, you can have them prescribed in a manner that is safe for you and our community. We proudly, strictly, and enthusiastically adhere to the guidelines set forth by the **Board of Medical Licensure**. Ours is thus a very structured program. We ask for a great deal of cooperation from you, and we appreciate your support and understanding.

We want you to feel like you are at the best place you could possibly be to get the pain care you need, and a place where you would send your loved ones for care. We are glad you are here. We look forward to working with you. We look forward to you feeling better.

Sincerely,

James Patrick Murphy, M.D.
Founder/Medical Director/President & CEO of Murphy Pain Center

Murphy Pain Center

EXPERIENCE

CARING

RELIEF

MURPHY PAIN CENTER BUSINESS COMPLEX
3002 Eastpoint Parkway
Louisville, KY 40223
PHONE 502-736-3636

MURPHY PAIN CENTER OF SOUTHERN INDIANA
207 Sparks Avenue, Suite #100
Jeffersonville, IN 47130
PHONE: 812-284-4357

WELCOME TO MURPHY PAIN CENTER

In order for you to make the most of your up-coming appointment, please bring the following items with you for your initial appointment:

1. Completed and signed "forms" from our website: **www.murphypaincenter.com**
2. All insurance cards. If your insurance is through your spouse or parent, we will need to know their date of birth and employer information.
3. Medical records and x-ray/MRI reports pertaining to the current pain condition. Your referring physician may have already sent these documents. Please verify we have received them before your scheduled appointment.
4. Picture ID showing your CURRENT residence.
5. Any co-pay or balance due.

Appointments

Co-payments and balances are **due at the time the services are rendered**, unless other arrangements have been made prior to scheduled appointment.

New patients need to arrive an hour early to scheduled appointment. New patient forms can be found www.murphypaincenter.com . If you arrive after your scheduled appointment time, **you may be asked to reschedule.**

If you cannot make your appointment and fail to call within 24 hours, you will be subject to a charge that is not billable through your insurance. Please see our "fee policy" for charges.

Prescription refills

According to the DEA regulations, you should be evaluated within 30 days of receiving (scheduled medication) prescriptions. Murphy Pain Center no longer does faxed medication refills. Refills for medications should be given at the scheduled office visit. Any changes in medication require an office visit.

Random Urine Drug Screens Pill counts

To be in compliance with the Murphy Pain Center controlled substance agreement, expect **mandatory and random** office visits for pill counts and/or urine drug screens. Because of this policy, patients must live within a 100 mile radius and/or a travel time of no more than two hours to our office.

Insurance Coverage

- You as the patient are responsible for knowing and understanding your insurance(s)/workers compensation claim. It is your responsibility to know if our providers are in network with your insurance.
- If you any have questions concerning your particular coverage, please contact your insurance company.
- If your insurance requires a referral to see a specialist, you are required to obtain your referral before your assessment visit.
- Murphy Pain Center will file all claims on your behalf as a courtesy to you. However, our office cannot accept

responsibility for negotiation of claims with insurance companies or other parties.

- It is very important to supply the Murphy Pain Center with the correct insurance information. If re-filing occurs due to incomplete or erroneous information given, this will result in a **$50.00 re-processing fee**.

Policies

Murphy Pain Center wants to provide you with the best care and services possible. In order to achieve this goal, we ask for your cooperation with and support of the above and following policies.

- If checks written are dishonored or returned for any reason, the check will be presented twice for payment and your account will be debited for the amount of the check and a processing fee of $50. This does NOT include your bank fees or the $25 charge from our office.
- If your account is delinquent and there is a need to send your account to an outside collection agency, there will be a service fee of 35% added to your balance.
- $25.00 fee for forms requiring more than a doctor's signature or requests for letters. *THIS DOES NOT INCLUDE WORK EXCUSES OR CUSTOMARY PAPERWORK ASSOCIATED WITH AN OFFICE VISIT.*
- Murphy Pain Center is a smoke free environment. We respectfully request that you also refrain from smoking in front of the building.
- Please refrain from using your cellular phone in the exam rooms during your office visit.
- Recording devices are not permitted.
- Children are **NOT PERMITTED** in the exam rooms. If a patient comes to an appointment with a child and does not have an adult to supervise the child during their office visit, **the patient may be asked to reschedule**. We recognize the inconvenience these policies may cause, but for the safety of the children and for the total attention from the provider, **we ask you refrain from bringing children to your appointments.**
- Medical records: all patients are entitled to one free copy of their medical records. If more than one copy is requested there will be a $1.00 per page fee added. All records will need to be picked up and release must be signed.
- In case of an emergency please call 911 or proceed to the nearest emergency room.

Directions

MURPHY PAIN CENTER
BUSINESS COMPLEX
3002 Eastpoint Parkway
Louisville, KY 40223

Traveling I-265 (Gene Snyder Freeway) from either direction (North or South bound) take exit number 30 (LaGrange Road * KY-146 "Anchorage/Pewee Valley"). Turn left off the ramp onto LaGrange Road heading toward Anchorage and away from Pewee Valley. Go approximately ½ mile and turn left onto Nelson Miller Parkway (into the "Eastpoint Business Center"). Go approximately ¼ mile and turn left onto Eastpoint Parkway. Go another ¼ mile and **Murphy Pain Center** will be in the **Horizon Business Center** on the left.

MURPHY PAIN CENTER
OF SOUTHERN INDIANA
207 Sparks Avenue, Suite #100
Jeffersonville, IN 47130

Traveling I-65 from either direction (North or South) take exit 1 and merge onto W 10th Street. Turn left at first red light onto Spring Street. Go 0.1 ml and turn left onto Sparks Avenue. Turn left at stop sign. Take entrance door with green awning. Take elevator to 1st floor. **Murphy Pain Center of Southern Indiana** is located in Suite #100.

Rev081612dt

Murphy Pain Center Patient Education Points

(This is a two page document.)

PATIENT NAME ____ Date ____________________

Proper Use

1. The patient must carefully follow instructions for use, including timing of doses; whether to take the medication with or without food; and any foods or other medications to avoid while taking the medication
2. Patients with low or impaired vision are advised to wear glasses when taking the medication and not take the medications in the dark.
3. The patient should read the prescription container label each time to confirm the dosage.
4. The patient should never use the medication after the expiration date.
5. The patient must never share the medication with others.
6. The patient must not take the medication with alcohol or other sedatives.
7. The patient should not take medication to help them sleep.
8. The patient should never break, crush, or chew the medication.
9. If appropriate, external heat, fever, and exertion can increase the absorption of transdermal products leading to potentially fatal overdose.
10. The patient should immediately contact the physician's office to report any adverse reaction.
11. It is illegal to share, sell, or give away controlled substances.

Driving and Work Safety

1. Controlled substances may cause sleepiness, clouded thinking, decreased concentration, slower reflexes, or incoordination, all of which may create a danger to the patient and others when driving or operating certain type of machinery.
2. You are encouraged to avoid, if possible, driving or engaging in other potentially dangerous work or other activities, for a specific period of time until the initial effects of the controlled substances no longer create such dangers.
3. You, the patient, are cautioned that ingesting other substances, such as alcohol, benzodiazapines, or some cold remedies, at the same time you are taking the controlled substances prescribed or dispensed may increase cognitive and motor impairment.

Pregnancy

If you are a female patient between the ages of 14 to 55 years of age with child bearing potential:

1. Understand that there are potential risks and benefits of controlled substance use during pregnancy. Do not use controlled substances or only use controlled substances on a minimal basis during pregnancy, unless the benefits of such use outweigh the risk.
2. If pregnant, planning to become pregnant, or in the likelihood that you may become pregnant, you and your obstetrician must make an individualized and deliberate determination that the benefits of prescribing or dispensing controlled substances sufficiently outweigh the risks for you and your baby, before accepting a prescription for controlled substances or taking these medications.
3. If there are any signs of adverse reaction or side effects, or conditions creating risk of danger to the patient or fetus, discontinue the medications immediately, contact your physician immediately, got to the emergency room, or call 911.

Potential for Overdose and Response

1. The use of controlled substances creates a risk of respiratory depression, which may result in serious harm or death and that the patient and others should be watchful for the following warning signs of over-medication:

    - intoxicated behavior, such as confusion, slurred speech, or stumbling
    - feeling dizzy or faint
    - acting very drowsy or groggy
    - unusual snoring, gasping, or snorting during sleep, and/or
    - difficulty waking up from sleep or difficulty in staying awake

Murphy Pain Center Patient Education Points

2. Immediately call “911” or an emergency service upon observing or experiencing any of the following conditions:

   - Patient cannot be aroused or wakened, or patient is unable to talk after being awakened.
   - Patient has shortness of breath, slow or light breathing, or stopped breathing.
   - Gurgling noises coming from the patient's mouth or throat.
   - Patient's body is limp, seems lifeless.
   - Patient's face is pale or clammy.
   - Patient's fingernails or lips are turning purple or blue, and/or
   - Patient's heartbeat is slow, unusual, or stopped.

Safe Storage of Controlled Substances

1. There is always the potential for partners, family members or others to improperly obtain the patient's controlled substances if those substances are not stored in a safe manner. Maintain the controlled substances prescribed or dispensed in the original container. Store controlled substances in a locked cabinet or other secure storage unit, that is cool, dry, and out of direct sunlight such as:
   - an existing safe
   - a cut-proof travel bag
   - a portable lock box designed for travel, or
   - a locking medical box.

2. You are discouraged from storing controlled substances in an unlocked medicine cabinet; in your car; or in a refrigerator or freezer unless specifically recommended by the prescribe or pharmacist.
3. Immediately notify the physician if any controlled substances prescribed or dispensed by the physician are stolen or improperly taken by another individual.

Proper Disposal

1. It is important to safely and appropriately dispose of unused controlled substances that have been prescribed or dispensed.
2. You should promptly dispose of unused controlled substances after the expiration date of the prescription or after the patient no longer requires the controlled substances to treat the medical condition.
3. In order to safely dispose of controlled substances, the patient should turn in the unused controlled substances as part of an approved governmental drug take-back program. There are some controlled substances that may be flushed down the toilet and most may be placed in a sealed plastic bag with coffee grounds or kitty litter and thrown in the trash (preferably when no one is there to observe-to minimize scavenging and pilfering by those seeking the leftover medications).
4. Personally remove any identifying information, including the prescription number, from an empty controlled substance container and then properly dispose of the empty container.

I have read this document or it has been explained to be me by the Murphy Pain Center of Southern Indiana practitioners and/or staff. I fully understand the information presented. All of my questions have been answered to my satisfaction.

Patient Signature____ Date __________________

Prescriber Signature(s)____________________ __________________ Date __________________

OFFICE USE ONLY:

Reviewed By: ____________________________________ Date: __________________

created 2-17-14jpm

Patient Agreement & Informed Consent for Controlled Substances Therapy

(There are two pages to this document.)

Name (please print)____ Date ___________________

PURPOSE: I understand that **the purpose** of this form is to document our discussion and my understanding of the potential risks, benefits, and alternatives associated with my treatment with controlled substances (including opioids), as well as, certain expectations related to proper medication use.

INTRODUCTION: I understand that licensed providers at **Murphy Pain Center are prescribing DEA controlled medicine** for me. Opioids (morphine-like drugs) are an example of these medicines. I acknowledge that we have had a discussion about the alternative therapies to controlled substances for managing pain that may exist for me. I understand this therapy was offered to me because my condition is serious and other treatments have not helped my pain to an acceptable level. I understand that my treatment with these medications is always subject to review and revision. I also am aware of the possible risks and benefits of other types of treatments that do not involve the use of opioids and controlled substances. I have been provided a simple and clear explanation of the key elements of my treatment plan. I have been encouraged to ask questions and all of my questions have been answered to my satisfaction, understanding, and educational level.

PREGNANCY: If I am a women between the ages of 14 and 55 with child bearing potential, I acknowledge that I have been counseled about the risks to the fetus when the mother has been taking opioids while pregnant - including the risk of fetal opioid dependency and neonatal abstinence syndrome (NAS). I understand if I am planning to become pregnant, if I become pregnant or if I am suspicious that I am pregnant, I will notify my prescriber immediately. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent. Birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid. I understand that I may be on other medications, such as sedatives that carry a higher risk of birth defects than opioids. **I further accept that any medication may cause harm to my embryo/fetus/baby and hold the prescriber and all staff harmless for injuries to the embryo/fetus/baby.**

SIDE EFFECTS: I am aware that the use of these medicines has certain risks, including, but not limited to: sleepiness or drowsiness, severe constipation, sexual dysfunction, hormonal abnormalities, nausea, sweating, itching, rashes, vomiting, dizziness, allergic reactions, dangerous slowing of breathing rate, worsening of sleep apnea, blood pressure problems, irregular heart rate, slowing of reflexes or reaction time, impaired immunity, seizures, physical dependence, addiction, tolerance to pain medications, inadequate pain relief, worsening of pain, accidental overdose, and cardiac arrest. I understand that dangerous reactions can occur when my medications are used along with some legal drugs (even over the counter drugs), illegal drugs, and alcohol. **I understand that use of opioids and other DEA controlled substances can cause death by a number of means.**

RESPONSIBILITY TO AVOID CERTAIN ACTIVITIES: I understand that even if I do not notice it, **my reflexes and reaction time** might still be slowed. I pledge to not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or may not be thinking clearly. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights, or being responsible for another individual who is unable to care for himself or herself.

SECURITY: I understand that there are people willing to risk their own lives or even kill me in order to steal these medications from me. I understand that most unlawfully diverted medications come from family, “friends”, and acquaintances, and I will keep my medications locked and under my control at all times.

ADDED RISK OF HIGHER DOSES: I understand that the use of high-dose or chronic opioid therapy is controversial and is not recommended without a demonstrated need and a plan for appropriate monitoring. I understand that many respected clinicians do not believe long-term use of these medications is beneficial for chronic pain. The need for progressively higher opioid doses may be a result of progression of the underlying condition, the development of tolerance, a psychiatric condition, or may indicate a substance use disorder or unlawful diversion. **I understand what the term “morphine equivalent dose” means. And I understand that**

if my prescribing clinician elects to provide or continue providing opioid therapy at a morphine equivalent dose of more than sixty (60) milligrams per day, my risks associated with opioid therapy - including my risk of dying - are substantially increased.

ALCOHOL: I am aware that I must not consume alcoholic beverages while taking these medications. Additionally, I understand that I must not use prescription or non-prescription medications containing alcohol while taking these pain medications. This is especially true if I am taking extended-release opioid (morphine-like) drugs. Consumption of alcohol while taking these medications may result in the rapid release and absorption of a potentially fatal dose of medication.

ADDICTION: I am aware that **addiction** can be defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug for non-medical purposes, and preoccupation with obtaining the drug. I understand that addiction is a life-threatening condition that may have no cure. I am aware that the development of addiction has been reported in medical journals as more common in a person who has a family or personal history of addiction and drug abuse. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

PHYSICIAL DEPENDENCE: I understand that **physical dependence** is an expected result of using these medicines. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine dose is markedly decreased, stopped or reversed by some other drug, I will likely experience a withdrawal syndrome. In the case of opioid withdrawal my symptoms could include any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling, and worsening of my usual pain. I am aware that opioid withdrawal is uncomfortable and possibly life threatening. **I also understand that the withdrawal from other drugs such as sedatives and anticonvulsants can be life threatening.**

TOLERANCE: I am aware that **tolerance** to analgesia means that I may require more medicine to get the same amount of pain relief. If this occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

REVERSAL ANTIDOTES: I am aware that certain other medicines such as nalbuphine (Nubain ™), pentazocine (Talwin™), buprenorphine (Buprenex™, Suboxone™), butorphanol (Stadol™), naloxone (Narcan) and naltrexone (Revia) may **reverse** the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a “withdrawal syndrome.” I agree not to take any of these medicines unless directed by healthcare provider and only after I have disclosed that I am taking an opioid as my pain medicine.

UNDERSTANDING: I have read this entire form or it has been read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. I know I may have a copy of this form. By signing this form voluntarily, I give my consent for the treatment of my pain with opioids and other controlled substances.

Patient Signature: ____ Date: ____________________

Clinician Signature(s):____

OFFICE USE ONLY

Reviewed By: ____ Date: _____________________

Created 2-17-14JPM

Murphy Pain Center Controlled Substances Prescriber- Patient Agreement

(This is a two page document.)

NAME (Please Print) ____ DATE ______________

I understand controlled substances medications (i.e. opioid pain medications, tranquilizers, etc.) have a potential for harm and are therefore closely controlled by the local, state and federal governments. I understand that any medical treatment is initially a trial, with the goal of treatment being to improve my quality of life and my ability to function and/or work. My progress will be assessed periodically to determine the benefits of continued treatment. Continued use is dependent on whether my prescribing provider and I believe that the medication usage benefits me. These drugs can be useful, but have high potential for misuse and are therefore closely regulated. This agreement will help my healthcare provider and me comply with controlled substance regulations. I agree to use opioids (morphine-like drugs) as part of my treatment for pain. The success of my treatment depends on trust, honesty and understanding of how opioids are used. I understand that violation of any part of this agreement may result in this medication being discontinued, as well as termination of my relationship with my provider. **I agree to the following conditions:**

SECURITY OF MEDICATIONS: I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. I will also report the stolen medication to my physician and complete a Lost/Stolen report. I agree that if my medications are lost, misplaced, stolen, or if I use them up sooner than prescribed, my physician may choose not to replace my medications.

FOLLOWING DIRECTIONS: Unless directed to by my prescriber, **I will not alter my medication** in any way, and I will take my medication whole. My medication will not be broken, chewed, crushed, injected, or snorted. I am responsible for my opioid medications. I will not allow my medications to be damaged. I will take my medication exactly as instructed and prescribed. I know that any change in dosage or directions must be approved by my licensed provider. I am responsible for taking the medication in the doses prescribed and for keeping track of the amount remaining. **I will not take more than is prescribed.**

TIME-LIMITED USE FOR ACUTE CONDITIONS: I understand that a controlled substance used to treat **an acute medical complaint** is for time-limited use. I will discontinue the use of the controlled substance when the condition requiring the controlled substance use has resolved.

WHEN OTHER CONDITIONS OR SYMPTOMS RISE: I will notify my healthcare provider of side effects that continue or are severe or impair me in any way. I will notify Murphy Pain Center by the next business day if I need to visit another physician or need to visit an emergency room due to pain or if I become pregnant.
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I agree to not request or accept a controlled substance medication from any other prescriber or individual while I am a patient at Murphy Pain Center. However, if another licensed provider, after being made aware of my Murphy Pain Center Agreement, still feels it is in my best interest to administer or prescribe a controlled substance for me, I will notify Murphy Pain Center by phone by the next business day. I will inform all of my healthcare providers of all medications I am taking, including herbal remedies. I understand that medications, including over-the-counter non-prescription medications can interact with opioid medications and can be dangerous.

NO ILLICIT SUBSTANCES: I will not use any illicit substances such as cocaine, marijuana, etc. I understand that the use of alcohol together with opioid medications is dangerous and can lead to death.

KEEPING APPOINTMENTS: It is my responsibility to schedule appointments for the next refill. I will communicate fully and honestly with my prescriber about my pain level and my activities. I understand that in order to more thoroughly evaluate my plan of care as it pertains to the use of controlled substances, I may have additional visits scheduled at my provider's discretion. I will keep all my Murphy Pain Center appointments. If I must reschedule, I will notify Murphy Pain Center of Southern Indiana prior to my scheduled time. If an appointment for a prescription refill is missed, I will request another appointment as soon as possible. I know that immediate or emergency appointments to address medication issues may not be available. **However, I understand that I am allowed to seek the services of another healthcare provider in the event of an emergency or acute situation**.

REFILLS: Refills will not be made as an "emergency." They will be made at planned clinic visits, during regular business hours. I will not expect any medications will be prescribed during the evening or on weekends. I do not expect prescriptions to be written in advance due to vacations, meetings or other commitments. I do not expect my prescriptions to be mailed. I expect that a government issued picture ID will be required to pick up prescriptions.

ONE DESIGNATED PHARMACY: I will designate and use only one pharmacy for all of my controlled substance medications and give the Murphy Pain Center of Southern Indiana full permission to communicate with the pharmacist about my medical care and medications. Unless I have been given authorization by Murphy Pain Center, controlled substance prescriptions can only be filled by a pharmacy in Indiana even if I am a resident of another state. I will allow Dr. Murphy and his associates to send a copy of this agreement to my other doctors and/or to the pharmacy where I obtain my prescriptions.

DRUG TESTING: My prescriber may perform drug testing on me. I agree that I may be called **at any time** to come in to the clinic for a count of all my remaining medications and/or a drug screen and I agree to come that day. **I agree to be responsible for any costs**

Murphy Pain Center Controlled Substances Prescriber- Patient Agreement

(This is a two page document.)

this may incur If requested to provide a urine sample or other type of sample if necessary. If I decide not to provide a urine sample, I understand that my prescriber may change my treatment plan. This might include discontinuation of my opioid medications or complete termination of our patient-prescriber relationship. The presence of a non-prescribed drug or illicit drug in my urine may be cause for termination of our relationship.

SHARING INFORMATION: I agree to allow my healthcare provider to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions if the he or she feels it is necessary. I will allow Dr. Murphy and his associates to receive information from any health care provider or pharmacist about use or possible misuse of alcohol and other drugs. I will allow Dr. Murphy and his associates to contact my family and friends to monitor my conditions. Furthermore, I consent to a criminal background check.

PRIMARY CARE PROVIDER RELATIONSHIP: I have and will maintain at all times a relationship with a primary care physician and keep him or her informed of all medications I am taking. **I agree to and understand the requirement that I have an annual** preventive health screening and physical exam by my primary care provider. If recommended, I will see a specialist and/or complete a screening exam to help determine whether I am developing an addiction or psychological illness. I agree to be responsible for any costs this may incur.

FUNCTIONAL GOALS: I understand that **the main treatment goal is to improve my ability to function.** I understand that in general, it is unrealistic for patients to expect complete resolution of their chronic pain with any specific treatment or combination of therapies. I understand that it is important to have a conversation with my provider about my treatment plan and set realistic goals for improvement. I pledge to work together with my provider towards improving my pain control and achieving specific functional goals. I understand that functional goals might include increasing physical activity level, resuming a job/hobby or improving the quality of sleep.

AN "EXIT STRATEGY": I understand the concept of an "exit strategy" regarding these medications. I agree that if any of the following goals are not attained this may be evidence of a failure of opioid therapy and discontinuation of some or all of my medications could be the most appropriate plan: (**1**) meaningful pain control; or (**2**) acceptable level of function; or (**3**) tolerable side-effects; or (**4**) stable and acceptable mental health and behavior: or (**5**) compliance the plan of care, laws, and regulations.

PATIENT EDUCATION: I acknowledge that **I have been educated on the following** matters through verbal or written counseling: (**1**) proper use; (**2**) impact on driving and work safety; (**3**) effect of use during pregnancy; (**4**) potential for overdose and appropriate response to overdose; (**5**) safe storage of controlled substances; and (**6**) proper disposal.

OFF-LABEL USE of MEDICATION: All prescription drugs in the US have a label approved by the FDA. This label provides an indication and dosage for the drug, but neither physician nor patient is legally bound to follow them. Studies cannot reliably evaluate all the combination treatments in complicated, difficult-to-treat conditions. **I understand that my treatment may include "off label" use of medications.**

DISCONTINUATION OF CARE: I understand that **my violation of any of the above conditions** may result in re-evaluation of my treatment plan and discontinuation of my medication. I could be gradually taken off these medications or even discharged from the clinic. If my violation involves obtaining controlled substances from another individual, as described above, I may also be reported to my physician, medical facilities and other authorities, including the police.

I HEREBY AGREE: I have read this agreement or it has been explained to me by the Murphy Pain Center of Southern Indiana practitioners and/or staff. I fully understand the consequences of violating this agreement. I have been explained the risks and potential benefits of these therapies, including, but not limited to, psychological addiction, physical dependence, withdrawal and over dosage. All of my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby agree to participate in the opioid medication therapy and acknowledge that I have received this document.

Patient Signature ____ Date ____________________

Practitioner Signature ____ Date ____________________

OFFICE USE ONLY

Review by:____ **Date:**____________________________

Created 2-17-14JPM

Murphy Pain Center of Southern Indiana

Family Treatment Agreement

We at Murphy Pain Center of Southern Indiana realize that families may become concerned about their loved ones during the course of their chronic pain treatment. We want to make sure that all concerned parties have the opportunity to voice their concerns and have their questions answered within the boundaries of the federal privacy laws.

First, some things we cannot do:

- We cannot discuss anything about the patient without the specific permission of the patient being treated. The Health Insurance Portability and Accountability Act (HIPAA) enacted in April of 2003 gave very firm laws about what information cannot be discussed without implicit permission of the patient.
- We cannot see you without the patient present. We cannot see you in lieu of the patient. The patient is our primary concern and responsibility.

With that being said, there are some general things related to the treatment of patients with chronic pain, especially with controlled substances of which you should be aware:

- These medications can impair functioning. Patients should not drive, operate heavy machinery, or serve in any capacity related to public or personal safety if they feel tired or mentally foggy.
- **The risks of taking opioids and other controlled substances include but are not limited to: skin rash, itching, constipation, sexual dysfunction, sleeping abnormalities, breathing difficulties, blood pressure problems, sweating, sedation, altered mental status, worsening of pain, impaired immunity, physical dependence, physical tolerance, and addiction.** Use of opioids and controlled substances can even cause death by a number of means.
- They can also cause birth defects. **Murphy Pain Center will need to be aware if the patient is considering pregnancy, becomes pregnant, or can possibly become pregnant.**
- **Tolerance** to medications may develop, which means the loss of effect of the current dose and the need to increase the dose in order to maintain effective pain control. However, patients should not increase their doses unless directed by their doctor or Dr. Murphy and his associates.
- The patient could become **physically dependant** on these medications. This means that if the dosage is diminished, withdrawal symptoms can occur. This condition can be life threatening and includes, but not exclusively, sweating, nervousness, abdominal cramps, diarrhea, mood disturbances, blood pressure, and heart problems.
- The patient could become **addicted** to these medications. Understand, however, that physical dependence and tolerance is not the same as addiction. Addiction means: loss of control with regard to the drug, preoccupation with acquiring the drug, compulsive use outside of that which is usual and customary, or continued use of the medication in spite of the knowledge that it could result in psychological, physical social, economic and legal harm.

There are responsibilities patients receiving these medications have. These include but are not limited to:

- Submitting to periodic unannounced assessments of their urine and/or blood to determine their adherence to the plan of care and to assess for toxic levels of medications or potential drug interactions.
- To help the Murphy Pain Center understand the rate at which they use their medications, and in order to more effectively adjust the dose, they may be called **at any time** to come in to the clinic for a count of all their remaining medications and they agree to come that day.
- If their prescription of medication is lost, misplaced or stolen, or used it up sooner than prescribed, they understand that **it may not be replaced.**
- They may not allow other individuals to take their medications or allow their medications to be damaged in any way.
- They will allow Dr. Murphy and his associates to receive information from any health care provider or pharmacist about their use or possible misuse of alcohol and other drugs
- **They will use only one pharmacy for all of their controlled substance medications** and give the Murphy Pain Center full permission to communicate with the pharmacist about their medical care and medications.
- They will file a police report if their medications are lost or stolen.
- They understand that **the main treatment goal is to improve their ability to function and/or work.** In consideration of that goal and that fact that they are (or may be) given potent medication to help them reach that goal, **they agree to help themselves by the following better health habits:** exercise, weight control and the non-use of tobacco and alcohol. They understand that only through following a healthier lifestyle can they hope to have the most successful outcome to their treatment.
- They understand that **if they violate any of the above conditions,** their controlled substance prescriptions and/or treatment with Murphy Pain Center may be ended. If the violation involves obtaining controlled substances from another individual, they may also be reported to their primary care physician, medical facilities and other authorities.

If at any time you have any questions or concerns please don't hesitate to contact the office, even if we cannot share any information with you, we can receive any information you wish to share. We always welcome your presence at the patient's visit (with the patient's permission). Your input and participation can make the difference between a successful course of treatment and an unsuccessful one.

Patient signature____ Date____________________

Family Member(s) signature(s)________________________________ Date____________________

____ Date____________________

Practitioner signature____________________________________ Date____________________

Murphy Pain Center

of Southern Indiana

CANCELLATION AND "NO SHOW" POLICY

Obtaining an appointment, especially one that will fit into your schedule is sometimes hard to come by. We at Murphy Pain Center would like to decrease the difficulty you may experience in obtaining your follow-up appointments. The following policy is our effort to decrease missed appointments that could have been filled by patients needing appointments or overbooking. For cancellations with less than 24 hours advance notice, the fee is $15.00. If you simply don't show for an appointment, the fee is $20.00.

COLLECTION FEES

Payment is expected at the time of service. If payment cannot be made in full, you are expected to pay 20% or $25.00 of the balance, whichever is greater. If account balance is $25.00 or less, then payment is due in full. Payment MUST be made monthly or your account is considered for collection. If your account is turned over to an outside agency, a 35% surcharge will be added to your account.

OTHER FEES

We bill your insurance as a courtesy to you. It is your responsibility to know your insurance and make sure we are filing with the correct carrier. This is especially true when the visit is related to Motor Vehicle or Worker's Comp. If we have to refile claims on your behalf, a $50.00 insurance reprocessing fee will be assessed.

For forms such as disability or FMLA, there is a minimum fee of $25.00.

If checks written are dishonored or returned for any reason, the check will be presented twice for payment and your account will be debited for the amount of the check and a processing fee of $50. This DOES NOT include your bank fees. If in the event a check does not clear the account on the second presentment and is returned to our office, your account will be charged a $25.00 returned check fee.

I have read the above policies and understand they are not covered by insurance. I am aware I am responsible for these charges.

Patient signature:____ Date:______________

Office Use Only:

Review by:____ **Date:**__________________________________

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 READ IT CAREFULLY.

We are committed to protecting medical, billing and other information about you. We create a record of the care and services you receive at or by Murphy Pain Center. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice will tell you about the ways in which we use and disclose information about you. It also describes your rights and our duties regarding the use and disclosure of your information. We reserve the right to change this Notice and 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. We will post a copy of the current Notice. We are required by law to maintain the privacy of medical information that identifies you, give you this Notice of our legal duties and privacy practices, and follow the terms of our most current Privacy Notice.

Use & Disclosure of Information About You: The following categories describe different ways that we are permitted to use & disclose medical information. These examples are not exhaustive.

For Treatment. We may use your medical information to provide, coordinate, or manage your health care. We may disclose your medical information to employees, students, volunteers, physicians, other health care providers, and other individuals who are involved in providing treatment to you.

For Payment. We may use & disclose information about you so that the treatment and services you receive may be billed & payment may be collected from you, an insurance company or a third party.

For Health Care Operations. We may use & and disclose your information about you for health care operations. These uses & disclosures are necessary to provide quality health care and to support the daily activities related to health care. These activities include but are not limited to investigations, oversight or staff performance reviews, conducting or arranging for other health related activities, underwriting & other insurance-related activities, business planning or development, & internal grievance resolution.

Appointment Reminders. We may use & disclose your information to remind you of an appointment with us.

Business Associates. We may use & disclose your information with third party "business associates" that perform various activities, such as, transcription services.

As Required By Law. We will disclose your personal health information when required or authorized by law.

To Avert a Serious Threat to Health or Safety. We may use & disclose information about you when necessary to prevent a serious threat to your health & safety or the health & safety of the public or another person. Such disclosure would be to the target of the threat or to someone able to help prevent the threat.

Your Rights Regarding Information About You:

Right of Access. You have the right to inspect & obtain a copy of information that we maintain about you. We may deny your request to inspect or obtain a copy in certain limited circumstances. If you are denied access to information, you may request that the denial be reviewed in certain circumstances.

Right to Amend. If you feel that information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must submit a written request, along with a reason that supports your request. We may deny your request if you ask us to amend information that was not created by us, is not part of the information that you would be permitted to inspect & copy; or is already accurate & complete as originally stated.

Right to Receive an Accounting. You have the right to request an accounting of certain disclosures made by us. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to your, to family members or friends involved in your care, or for notification purposes.

Right to Request Restrictions. You have the right to request a restriction or limitation on the information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the information we disclose to someone who is involved in your care, like a family member or friend. Your request must be in writing, must state the specific restriction requested & to whom the restriction you want to apply. We will comply with your request unless the information is needed for emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing.

Right to a Paper Copy of This Notice. You have the right to obtain a paper copy of this Notice .

Other Uses of Medical Information:

Other uses & disclosures of information not covered by this Notice or the laws that apply to us will be made only with your signing an authorization form.

If you have any questions about this Notice of Privacy Practices, you may contact our Privacy Officer at 502-736-2901.
If you believe your privacy rights have been violated, you may contact the Department of Health & Human Services. You will not be penalized for filing a complaint.

Eff. 12/17/07JL

MUPRHY PAIN CENTER – NEW PATIENT EVALUATION

Date: ____________________ **DOB:** _______________ **AGE:** _________

NAME: ____ **PHONE:** __________________________

Referring Physician: ___________________________________ **PHONE:** __________________________

Primary Care Physician: _______________________________ **PHONE:** __________________________

Is your pain a WORKMAN's COMP case? ☐ YES ☐ NO **Is your pain due to MVA?** ☐ YES ☐ NO

Please provider your EMAIL Address:

HISTORY OF PRESENT ILLNESS

1. **Please describe your pain in one sentence (ex: "My back hurts."):**

   ____

2. **What caused your pain?**

   ☐ Work-related accident ☐ Accident at home ☐ Work-related, not accident ☐ Motor Vehicle Accident

   ☐ Following Surgery ☐ Following Illness ☐ Pain began, no reason

   ****If work related, please describe how:** ☐ injury from repetitive activity ☐ struck by falling object

   ☐ fall ☐ lifting object ☐ pushing Other: ____

3. **Date your pain began:**

   ☐ Past 2 weeks ☐ 3-6 months ☐ 1-2 years ☐ > 5 years
   ☐ 2 wks – 3 months ☐ 6 mo – 1 year ☐ 2-5 years

4. **Location of your pain (check all that apply):**

   ☐ Head ☐ (R) Hand ☐ (R) Leg ☐ Anterior Chest Wall
   ☐ Neck ☐ (L) Hand ☐ (L) Leg ☐ Abdominal Pain
   ☐ (R) Shoulder ☐ Upper Back ☐ (R) Knee ☐ Testicular Pain
   ☐ (L) Shoulder ☐ Lower Back ☐ (L) Knee
   ☐ (R) Wrist/Arm ☐ (R) Hip ☐ (R) Ankle/Foot
   ☐ (L) Wrist/Arm ☐ (L) Hip ☐ (L) Ankle/Foot

5. **Describe your pain (check all that apply):**

   ☐ Sharp ☐ Numbness ☐ Cramping ☐ Nagging
   ☐ Dull/Aching ☐ Pressure ☐ Spasm
   ☐ Throbbing ☐ Electric/Shooting ☐ Penetrating
   ☐ Pins/Needles ☐ Burning ☐ Tender
   ☐ Stabbing ☐ Stinging ☐ Gnawing

6. **Please rate your pain:**

Good Day:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Bad Day:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Current:	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

7. **Is your pain always the same?** ☐ **YES** ☐ **NO**

8. **Duration of your pain:** ☐ Rare ☐ Occasional ☐ Frequent ☐ Constant

9. **What makes your pain worse (check all that apply):**

☐ Heat
☐ Cold
☐ Activity
☐ Rest
☐ Lying Down
☐ Quiet
☐ Sitting
☐ Standing
☐ Walking
☐ Medication
☐ Massage
☐ Lifting
☐ Bending
☐ Activities of daily living
☐ Weight bearing activities

10. **What makes your pain better (check all that apply):**

☐ Heat
☐ Cold
☐ Activity
☐ Rest
☐ Lying Down
☐ Quiet
☐ Sitting
☐ Standing
☐ Walking
☐ Medication
☐ Massage

11. **CHECK any of the treatment therapies listed below that you have had in the past; then**

CIRCLE the treatment(s) that were HELPFUL

☐ Acupuncture
☐ Bed Rest
☐ Biofeedback
☐ Bracing
☐ Carpal Tunnel Injections
☐ Celiac Plexus Injection
☐ Chiropractor
☐ Epidural Blocks
☐ Facet Injections
☐ Group Therapy
☐ Heat therapy
☐ Herbal Remedies
☐ Hypnosis
☐ Injected Medication
☐ IV Injections
☐ Joint Injections
☐ Massage Therapy
☐ Magnet Therapy
☐ Marijuana
☐ Narcotic Pain Medication
☐ Nerve Blocks
☐ Physical Therapy
☐ Piriformis Injection
☐ Psychiatrist/Psychologist
☐ RFTC
☐ SI Joint Injection
☐ Spinal Cord Stimulator
☐ Spinal Pain Pump
☐ Sympathetic Blocks
☐ TENS
☐ Topical Ointments
☐ Traction
☐ Trigger Point Injections
☐ Ultrasound
☐ **NONE**

12 What time of day is your pain worse? ____

13. What time of day is your pain least? ____

14. Does your pain interrupt your sleep and how often? _________________________________

15. Previous Diagnostic Studies (check all that apply): ☐ **NONE**

☐ MRI	☐ Bone Scan	☐ Urine Drug Screen
☐ CT	☐ Discogram	☐ EMG
☐ Myelogram	☐ Blood test	☐ Other ____________________________

16. Please list any surgery you have had that is related to your current pain: ☐ **NONE**

____

17. Who was your surgeon? ____

18. Did surgery help your pain? ☐ **YES** ☐ **NO**

19. Have you been treated by another pain management physician? ☐ **NO** ☐ **YES**

20. Please list name of pain physician and why you left? __________________________________

____

21. Please list medications you have trialed but are no longer taking (check all that apply): ☐ **NONE**

☐ Actiq	☐ Darvocet	☐ Lunesta	☐ Oxycontin	☐ Skelaxin
☐ Aleve	☐ Dilaudid	☐ Lyrica	☐ Oxyfast	☐ Stadol Nose Spray
☐ Ambien	☐ Duragesic	☐ Methadone	☐ Paxil	☐ Talwin
☐ Aspirin	☐ Effexor	☐ Mexilitine	☐ Percocet	☐ Tegretol
☐ Avinza	☐ Elavil	☐ Mobic	☐ Prednisone	☐ Topamax
☐ Baclofen	☐ Embeda	☐ Morphine	☐ Prozac	☐ Tylenol
☐ Celebrex	☐ Flexeril	☐ Naproxyn	☐ Relafen	☐ Ultram
☐ Clonazepam	☐ Hydrocodone	☐ Neurontin	☐ Remeron	☐ Valium
☐ Clonidine	☐ Kadian	☐ Nortriptyline	☐ Robaxin	☐ Zanaflex
☐ Codeine	☐ Lidoderm	☐ Nucynta	☐ Soma	☐ Zoloft
☐ Cymbalta	☐ Lortab	☐ Opana	☐ Savella	

MEDICATIONS & ALLERGIES ☐ NONE

1. Please list all PAIN medication(s) (If more space needed, please make list & bring to appointment):

NAME	STRENGTH(mg)	TIMES per DAY

2. **Please list all <u>NON-PAIN</u> medication (include herbal medications & vitamins)**

NAME	STRENGTH(mg)	TIMES per DAY
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________

3. **MEDICATION ALLERGIES:** ____

4. **ENVIROMENTAL/FOOD ALLERGIES:** ____________ ________________________

PHARMACY (Name, Address, Phone): ______________________________________

HISTORY:

1. **Do you have any of the following medical conditions? (Check all that apply):** ☐ **NONE**

☐ Anemia	☐ Gastric Ulcers	☐ Lupus
☐ Asthma	☐ Gastritis	☐ Nerve Damage
☐ Bronchitis	☐ Glaucoma	☐ Osteoarthritis
☐ Cancer	☐ Hearing Loss	☐ Poor Vision
☐ Cirrhosis	☐ Heart Disease	☐ Rheumatoid Arthritis
☐ Colitis	☐ Hepatitis	☐ Sarcoidoisis
☐ COPD	☐ HIV/AIDS	☐ Sleep Apnea
☐ Diabetes (insulin controlled)	☐ Hypertension	☐ Thyroid (high)
☐ Diabetes (oral medications)	☐ Irritable Bowel	☐ Thyroid (low)
☐ Epilepsy	☐ Kidney Disease	☐ **PACEMAKER**
☐ Fibromyalgia	☐ Kidney Stones	☐ **Internal Defibrillator**

☐ OTHER ____

2. **Please list surgeries you have undergone in your lifetime:** ☐ **NONE**

____

____

____

3. **Please list any medical conditions in your family and identify the family member (i.e. mother – heart disease ; father – hypertension; sister – anemia and etc.)**

FATHER ____ **NONE** ☐

MOTHER ____ **NONE** ☐

SISTER(S) ____ **NONE** ☐

BROTHER(S) ____ **NONE** ☐

OTHER ____

4. **Does anyone in your family have a history of drug or alcohol abuse?** ☐ **NO** ☐ **YES**

____

5. **Who lives with you presently:**

☐ Live alone ☐ Live with spouse ☐ Live with life partner

☐ Live with friend/roommate ☐ Live with children ☐ Live with grown children

6. **What is your current occupation?**

____

☐ Full time ☐ Part time ☐ Unemployed ☐ Retired ☐ Not working (due to pain) ☐ Disabled (due to pain)

7. **What is your highest level of education?**

☐ Some High School ☐ GED ☐ Graduate Degree (Masters)

☐ High School Graduate ☐ Some College ☐ Graduate Degree (Doctorate)

☐ Vocational School ☐ College Degree

8. **Have you ever been arrested or incarcerated?** ☐ **YES** ☐ **NO**

____

9. **Tobacco Use:** ☐ **NEVER** smoked ☐ **Former** Smoker ☐ **Current** every day smoker

☐ **Current** some day smoker ☐ **Heavy** daily smoker ☐ **Light** daily smoker

Total number of years smoked: ________ # Packs/day _____________

10. **Alcohol Use:** ☐ **NEVER** ☐ **Occasionally** ☐ **Often**

Average drinks per day: _______________ Type _____________________

Do you ever drink to relieve your pain? ☐ Never ☐ Occasionally ☐ Often

11. **Do you have a personal history: DRUG Abuse? ☐ YES ☐ NO ALCOHOL Abuse? ☐ YES ☐ NO**

Have you ever been in rehab? ☐ YES ☐ NO

____

12. **Are you now suing; have you ever sued; or do you plan to sue because of your pain?** ☐ NO ☐ YES

If you answered yes, please explain: ____

____

13. **Have you received or are receiving any form of financial compensation for your pain?** ☐ NO ☐ YES

☐ Worker's Compensation ☐ Government Disability ☐ Insurance ☐ Accrued Sick Leave ☐ Lump Sum Payment

NEW PATIENT INFORMATION CERTIFICATION

I certify that I have answered truthfully all questions on the New Patient Evaluation form and have not knowingly withheld any information concerning any of the above problems, either past or present.

I understand that the physicians and staff of Murphy Pain Center will only be evaluating my condition as it relates to my pain. Any condition which is not specifically pain-related must be followed and evaluated by my primary care physician.

I understand that the procedures and medications which may be prescribed by Murphy Pain Center can potentially have adverse effects on the status of one's fertility as well as a developing fetus. I will notify my Murphy Pain Center physician if there is any change in my fertility status or pregnancy status.

I understand that the procedures and medications which may be prescribed by Murphy Pain Center can potentially impair my ability to drive and operate machinery. I pledge to never drive impaired.

I understand that it may be at times difficult to obtain prompt consultation with the physicians or staff of Murphy Pain Center. If there is ever a significant deterioration on my function or progression of symptoms, I will seek prompt Medical attention elsewhere.

____ __________________

Your Signature **DATE**

____

Print Name

Thank you,

____ __________________

Practitioner **DATE**

Office Use Only:

Review by:____________________________________ **Date:**______________________________

PRIVACY CONSENT for Purposes of Treatment, Payment and Health Care Operations

Name (please print) ____

I consent to the use or disclosure of my protected health information by Murphy Pain Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care services or to carry out the Practice's healthcare operations.

I understand that Murphy Pain Center may condition its diagnosis or treatment of me upon my consent to allow its use or disclosure of my protected health information.

I acknowledge Murphy Pain Center has provided me a copy of its Notice of Privacy Practices, which provides a more detailed description of the uses and disclosures allowed by this consent. I acknowledge my right to review the Notice of Privacy Practices prior to signing this consent. The practice reserves the right to change the privacy practices outlined in the Notice of Privacy Practices. I may obtain a revised copy by asking for one at the time of my next appointment.

I understand that I have the right to request restriction on how the Practice uses and disclosures of my protected health information for treatment, payment, or the health care operations. Murphy Pain Center is not required to agree to any restriction, but if it does, the restriction is binding.

I have the right to revoke this consent in writing, except to the extend Murphy Pain Center has taken actions in reliance on this consent.

I authorize Murphy Pain Center to **disclose personal information about me to the following person(s)**. Information disclosed may include, but not exclusive: account balance, billing information, appointments, treatment, plan of care, and prescriptions. This authorization expires upon my death, unless revoked by me in writing.

➡ ________________________________ ________________________________
Person **Relationship to Patient**

➡ ________________________________ ________________________________
Person **Relationship to Patient**

➡ ________________________________ ________________________________
Person **Relationship to Patient**

X____ ____________________
PATIENT or Personal Representative SIGNATURE Date

____ ____________________
Witness Date

Created 5/20/14dt

Murphy Pain Center of Southern Indiana
Registration Form

Date: ____________________ **Home Phone:** ______________________________ **Cell Phone:** _________________________

Name: ____ SSN: _______________________________
(Last) (First) (Middle)

Address: _____________________________ City: _____________________________ State: ______________ Zip:___________

Sex: M F Date of Birth: _________________ Age: ______ Marital Status: Single Married Widowed Divorced

Ethnicity: Non-Hispanic/Non-Latino **OR** Hispanic/Latino

Race: African American Asian White American Indian Pacific Islander Decline

Primary Language: English Spanish Other ______________________

Employer: ____ OR Retired Unemployed Student Disabled

Employer Address: ______________________________________ City, State, Zip: ____

Occupation: ____ Business Phone: (____)_____________________________

IN CASE OF EMERGENCY NOTIFY: ____

Phone: ____________________________________ Relationship to patient: ____

INSURANCE INFORMATION

I. PRIMARY Insurance Company:____

ID #:_______________________________________ Group #:________________________

Name of Policyholder:____ Policyholder's Date of Birth:_________________

Their relationship to you: ☐ Self ☐ Spouse ☐ Parent ☐ Other_____________________
Does your PRIMARY Insurance Company require a REFERRAL NUMBER from your Primary Physician? ☐YES ☐NO

II. SECONDARY Insurance Company:____

ID #:____ Group #__________________________

Name of Policyholder:____ Policyholder's Date of Birth:_________________

Their relationship to you: ☐ Self ☐ Spouse ☐ Parent ☐ Other_____________________
Does your SECONDARY Insurance Company require a REFERRAL NUMBER from your Primary Physician? ☐YES ☐NO

III. **Do you have Medicaid or Passport?** ☐YES ☐NO

IV. MEDICARE Questionnaire: **(If you do not have Medicare, please skip to Section V.)**

A. **Do you have any group health plan coverage through your current employer?** ☐YES ☐NO **(If no, skip to B.)**

How many employees, including yourself, work for your employer? (All locations.) ☐ 1-19 ☐ 20-99 ☐ 100 or more

Are you retired? ☐YES ☐NO Are you on COBRA? ☐YES ☐NO

B. **Do you have any group health plan coverage through your spouse's employer?** ☐YES ☐NO

How many employees, including your spouse, work for his or her employer? (All locations.) ☐ 1-19 ☐ 20-99 ☐ 100 or more

Is your spouse retired? ☐YES ☐NO Does your spouse have coverage through COBRA? ☐YES ☐NO

C. **Are you receiving Black Lung Benefits?** ☐YES ☐NO

V. Are we seeing you relating to an injury or illness which another party could be held responsible or could be covered under no-fault, automobile, worker's compensation, or liability insurance? ☐YES ☐NO **(If no, skip this section.)**

Type of accident: ☐ Motor Vehicle ☐ Work Related (W/C) ☐ Other: ______________________________

If Motor Vehicle (MVA), is your PIP exhausted? ☐YES ☐NO Date of accident or injury:____________________

Part(s) of body injured:________________________________Employer (if W/C):______________________

Name of Insurance Company:___________________________ Claim #:______________________________

Case Worker or Adjuster's Name:_________________________ Phone #: ____________________________

Release of Records, Request for Treatment and Release of Information & Assignment of Benefits:
I authorize Murphy Pain Center to release the necessary information regarding services as rendered to me and allow a photocopy of my signature to be used in submitting and processing of health insurance claim forms.

I hereby request treatment from Murphy Pain Center of Southern Indiana, and I authorize Murphy Pain Center of Southern Indiana to obtain any and all medical records necessary for my care. I specifically release Murphy Pain Center from all liability in obtaining these records as outlined in the Privacy Act or other such legislation.

I authorize my health insurance carrier to issue payment of benefits directly to James Patrick Murphy, MD, PSC a.k.a. Murphy Pain Center of Southern Indiana for payment of services rendered.

____ ____________________________

Signature Date

Non-Covered Services, Referrals, and Copayments:
I accept responsibility for any charges not covered by my insurance. I will be responsible for verifying the practitioners at Murphy Pain Center of Southern Indiana are participating providers with my insurance carrier(s). If a referral is needed, it is my responsibility to obtain this before my appointment. I understand co-payments and balances due are expected at the time of service.

I attest the information provided in this registration is accurate and complete. I agree to report any changes in my address, phone number or insurance status. I understand dishonest or misleading information may be cause for termination.

____ ____________________________

Signature Date

****As a service to our clients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your home/cell phone number, you consent to receiving such calls at this number.**

Office Use Only:

Review by:_______________________________________ Date:___________________________