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MODERN PAIN

# PAIN AGREEMENT

This is a medication contract between (patient name) _____ and Munshi Modern Pain. The purpose of this agreement is to outline policies regarding controlled substances, including narcotics (Hydrocodone, Morphine, Fentanyl, etc). This agreement will help make sure we comply with state and federal regulations. A trial of opioid therapy will be considered for moderate to severe pain with objective of reducing pain and improving function. The success of this treatment will be based on honesty and trust between the physician and the patient. Please read through this agreement thoroughly and ask for clarifications or questions about anything you do not understand.

1. Only one physician will prescribe any narcotics. If there is a change or an emergency situation our office will be notified immediately.
2. Only one pharmacy will be used for any controlled substance prescriptions.
3. Medication must be taken only as prescribed
4. If medication is lost or stolen, a police report must be filed, and the office must be contacted immediately. Medication will not be replaced for any reasons.
5. Random urine drug screenings will happen during the course of treatment and you are expected to comply. Positive results of illicit drugs or negative results of the prescribed drug may result in termination from the clinic.
6. Opioid analgesics will not be prescribed over the phone nor will prescriptions be sent through the mail.
7. The prescribed medication is for the patient whom it is prescribed to and nobody else.
8. I will bring all bottles of opioids to my appointment and a pill count may take place. Inconsistent pill counts may cause for termination from the clinic.
9. Prescription refills or issues will only be addressed during regular office hours, not after hours or weekends.
10. I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking prescription monitoring program website periodically throughout my treatment period.
11. The use of any illicit/ illegal drugs (Cocaine, Marijuana, Heroin, Meth, etc.) is forbidden with opioid treatment.
12. The use of alcohol during opioid treatment is forbidden.
13. Munshi Modern Pain recommends patient do not drive or operate heavy machinery while on opioids or other controlled substances.
14. I will not attempt to obtain any opioids from any other provider.
15. There are side effects associated with opioid therapy and they include: Nausea, vomiting, constipation, sleeping abnormalities, sexual dysfunction, respiratory depression, sedation, edema, sweating, skin rash, and / or death.

Munshi Modern Pain
12835 Gulf Freeway, Houston, TX 77034 | 5420 West Loop South Bellaire, TX 77401 Suite 1100
PHONE: 281-922-9979
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16. There is a risk that you could become addicted to opioids. Addiction is a chronic neurobiological disease and characterized by continued use despite harm, impaired control over use, compulsive use and cravings. Addiction may affect the patient's quality of life.
17. You agree to allow your physician to contact any healthcare provider, pharmacy, family members, legal agency, or regulatory authority to obtain or provide information regarding your care only if the physician finds it necessary.
18. You must call the clinic 5 days prior to your refill date to ensure your refill is ready on time for your pickup.
19. You must have a valid Texas license.
20. You must show up for your follow ups to evaluate therapy.
21. Pharmacy that will be used for all of my controlled substances will be:

Pharmacy: _____ Phone: _____

Any violation of this agreement will cause for termination of controlled substances and possibly from the clinic.

Thank you for your understanding. Our goal is to provide compassionate care while ensuring the health and safety of our patients and community.

Signature (patient): _____ Date: _____

Signature (physician): _____ Date: _____

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## Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### Uses and Disclosures

**Treatment.** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**Payment.** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

**Health care operations.** Your health information may be used as necessary to support the day-to-day activities and management of Munshi Modern Pain. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**Law enforcement.** Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

**Public health reporting.** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

**Other uses and disclosures require your authorization.** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

### Additional Uses of Information

**Appointment reminders.** Your health information will be used by our staff to send you appointment reminders.

**Information about treatments.** Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

### Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

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**Munshi Modern Pain, Duties**

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

We also are required to abide by the privacy policies and practices that are outlined in this notice.

**Right to Revise Privacy Practices**

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

**Requests to Inspect Protected Health Information**

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Acting Manager or Dr. Omer Munshi. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

**Complaints**

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

**Attn. Manager**
**Munshi Modern Pain**
**12835 Gulf Freeway**
**Houston, TX 77034**

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.
By signing below I am confirming that I have read and understand Munshi Modern Pain's HIPPA privacy practices:

| Signature | Print | Date |
|---|---|---|

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# FINANCIAL POLICY

**Patient Name:** _____ **DOB:** _____

Munshi Modern Pain appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Munshi Modern Pain, for providing medical services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Munshi Modern Pain, the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____

(If guarantor is not the patient)

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## Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ Date _____

## Consent for Treatment and Authorization to Release Information

I hereby authorize Munshi Modern Pain, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Munshi Modern Pain, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature _____ Date _____

## Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call **48-hours** prior to canceling your office visit, and **72-hours** prior to cancelling your procedure appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

Munshi Modern Pain will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____ Date _____

## Self-Pay

I do not have health insurance and will be responsible for services rendered here at Munshi Modern Pain. I agree to pay Munshi Modern Pain, the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature _____ Date _____

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# PATIENT PORTAL

Munshi Modern Pain offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physician. Secure messaging can be a valuable communication tool, but as certain risks. In order to manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

**How to Secure Patient Portal Works**

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the Web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

**Protecting Your Private Health Information and Risks**

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

**Patient Acknowledgement and Agreement**

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

**Email Address:** _____

| _____ | _____ | _____ |
|---|---|---|
| **Print Name** | **Signature** | **Date** |

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**MUNSHI MODERN PAIN., LLC**
**Interventional Pain Specialists**
**Physicians Board Certified in Pain Management**

Dear Patient,
Our practice is growing!
•In an effort to keep our office administrative costs down, we must enforce our Patient Administration Fees Policy. This covers the staff time and office expenses required us to complete forms.
•We do not bill insurance companies or attorneys for these expenses. If you feel that these fees may be reimbursable, save your receipt(s) and submit them to your insurance company/attorney. You are responsible for any litigation/attorney fees to collect outstanding bills for these fees that are more than 90 days old.
•Payment is expected at the time the forms are picked up/mailed out; office visit/procedure appointment cancellation fees are expected at the next office or procedure visit.
We accept Visa, MC, Discover, cash or checks made out to MUNSHI MODERN PAIN

| | Amount Paid Fee | Cash / Check # | Date |
|---|---|---|---|
| 1.* Cancelled procedure less than **72 hours** prior to appointment / No show for procedures: | $150.00 | | |
| 2.* Cancelled office visit less than **24 hours** prior to appointment / No show for office appointment: | $ 25.00 | | |
| 3. Returned check fee: | $ 25.00 | | |
| 4. Dept. Motor Vehicle / Temporary Handicap Tag Application: | $ 25.00 | | |
| Renewals: | $ 25.00 | | |
| 5. Reprint of prescription fee | $15.00/ea | | |
| 6. Disability Forms (SS / Employer / EEO): | $ 45.00 | | |
| 7. Other: _FMLA_____ | $ 45.00 | | |
| 8. Photocopies of office paperwork / medical records: | $ 0.75 per page | | |

**$25.00 For Medical Records first 25 pages / then $0.75 per page there after**

Fees for paperwork for settlement evaluations / expert witness / court hearings / other –requested by your attorney or insurance/litigation company will be billed directly to them.

**IN THE EVENT** of an emergency, inclement weather or other extenuating circumstances, **PLEASE CALL** and leave a message. Our office staff will contact you and follow up.
If there are any questions or issues concerning these fees, you may speak with our office manager.
We appreciate your cooperation and look forward to continuing to help you achieve a more functional, less painful, Healthy and happy life.

*Sincerely,*

*Dr. Omer Munshi*
*The Staff of Munshi Modern Pain, LLC*

Patient Receipt
I understand and acknowledge the above administrative office fees. I understand these fees may change as needed without my prior notification.

Patient Signature Date

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## PHYSICIAN OWNERSHIP DISCLOSURE FORM

To:The patients of Munshi Modern Pain
During the course of your physician/patient relationship with Omer Munshi, MD at Munshi Modern Pain may refer you to Next Health, GenTox, Any MRI Facility, Doctors United Surgical Center, HPH, (the "Facility").

In connection with any referral to the Facility, you are hereby advised that Munshi Modern Pain has an investment interest in the Facility and therefore will receive, directly or indirectly, remuneration as a result of such referral.

This information is being provided to you at the time of Munshi Modern Pain first contact with you as a patient and will also be provided to you at the time of referral, if any, to help you make an informed decision about your health care. You have the right to choose your health care provider. You have the option of obtaining health care ordered by your physician at a different facility other than the Facility. You will not be treated differently by your physician, the physician's staff, or the Facility if you choose to use a different facility.

Should Omer Munshi M.D., (Munshi Modern Pain) at any time refer you to the Facility and you prefer to use a different health care provider, you will be advised of alternative health care providers and your right to choose one of these alternative health care providers.

_____
Patient name

_____
Patient Signature

Munshi Modern Pain
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# AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

**Patient Name:**_____ **Date of Birth:**_____

**Phone: H)**_____ **Phone: W)** _____

**Address:**_____ **City/State/Zip:** _____

**Please Note:** Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

**Facility Name:** _____ **Facility Phone:**_____

**Facility Address:**_____ **Facility Fax:**_____

**City, ST, Zip:** _____

**Dates and Type of information to disclose:**

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested:
_____

**The purpose of disclosure is:**

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

**This information may be disclosed and used by the following individual or organization:**

**Release To:** _____ _____

MUNSHI MODERN PAIN
12553 Gulf Freeway
Houston, Texas 77034
Phone# 281-922-9979 Fax# 281-929-0804

**Address:** _____ _____

**City, State, Zip:** _____ _____ ☐ **Please mail records.**

☐ **Please fax records.**

**Fax:** _____ **Phone:** _____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____.

**If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

**I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

**X**_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

**Date**

_____ _____

Printed name of Authorized Representative

Relationship / Capacity to patient

_____

Address and telephone number of authorized representative