

OFFICE POLICIES

- New patients will need to arrive to our office at least 15 minutes prior to your appointment. This allows time for paperwork and insurance updates.
- If you are **more than 5 minutes late** for your appointment, YOU MAY BE RESCHEDULED to the next available appointment and may be charged a **\$125.00 late fee**.
- If you are unable to keep your appointment for any reason, please call our office **24 hours in advance** to avoid a rescheduling fee. If you do not show up to or you fail to cancel your appointment 24 hours in advance, you will be charged a **\$150.00 "no-show" fee**. This will be billed to the patient, not your insurance company and you will not be rescheduled until this fee is paid.
- Please note **2 appointments** missed without cancelling (these do not need to be consecutive) will result in discharge from our care.
- It is the **patient's responsibility** to verify that we are a participating provider with his/her insurance plan and to understand his/her benefits.
- You will need to present your insurance card/s and photo ID at your initial visit (failure to have either will result in rescheduling once you have those documents available) and at the beginning of each new year and at each renewal or change of insurance. NO balances will be carried.
- **INSURANCE COPAYS MUST BE PAID AT THE TIME SERVICES ARE RENDERED.**

IF YOU ARE PRESCRIBED NARCOTICS:

- You must be seen monthly for refills. You must bring those medications to each office visit in the most recent pill bottle prescribed. Only bring medications prescribed by Dr. Claflin.
- Refill requests must be made **at least 72 hours** prior to running out of medication. This gives us enough time to refill your medication in a timely manner.
- We **DO NOT** replace lost or stolen meds for any reason, even with a police report.
- You will need to sign a medication contract with our office.

I have read and understand the policies listed above.

Patient Signature _____

PATIENT INFORMATION

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____ Home phone _____

Work phone _____ Cell/other _____ Email _____

Social Security Number _____

What is your preferred method of contact? Home phone Work phone Cell phone Email

Marital status (circle one) Single Married Separated Divorced Widowed

Race (circle one) American Indian Alaskan Native Asian Black Caucasian Other

Ethnicity (circle one) Hispanic Non-Hispanic Primary language: _____

Current employer _____ Phone # _____

Preferred pharmacy (Name/Address/Phone #) _____

Responsible Party (If other than above) _____

Address _____

City _____ State _____ Zip Code _____

Home phone _____ Work phone _____

INSURANCE INFORMATION (If this is a WORKERS COMPENSATION injury, please see the next page)

Do you have medical insurance? Yes / No Is this a workers compensation injury? Yes / No

Insurance (1) _____

Policy # _____ Group # _____

Name on policy _____ DOB _____ SSN _____

Insurance (2) _____

Policy # _____ Group # _____

Name on policy _____ DOB _____ SSN _____

SPOUSE INFORMATION (for emergency contact)

Spouses Name _____ DOB _____ SSN _____

Work phone _____ Cell phone _____

Who would we contact in case of an emergency *other* than your spouse?

Name _____

Work phone _____ Cell phone _____

This is an authorization of release of medical information and payment of medical benefits. I authorize the release of any medical information necessary to process this claim. Also, I request payment of medical benefits to the physician for service. I understand and agree that charges by Oklahoma Interventional Spine & Pain are to be paid in full, and I am responsible for the service and/or items not covered by my insurance company.

Signed _____ Date _____

WORKERS COMPENSATION INFORMATION

Is the reason for the visit a work-related injury? Yes _____ (answer questions below) No _____ (go to page 4)

Date of injury _____

Body part injured: _____

Workers Compensation Insurance _____

Employer _____ Contact _____

Address _____ City _____ State _____ Zip _____

Name of adjuster or case manager (if known) _____

Adjuster or case manager phone _____

Claim Number _____

HEALTH HISTORY

Name: _____ DOB: _____

Age: _____ Height: _____ Weight: _____ Sex: Male / Female

MEDICATIONS:

Please list all current medications, dose, and how often you take each medicine (if you need more space please write on the back of this paper)

Medication	Dose	How often?

ALLERGIES:

Have you ever had an allergic reaction to:

- Xray dye? Yes / No
- Morphine, Demerol or other narcotics? Yes / No
- Novocain or other anesthetics? Yes / No
- Aspirin or other pain remedies? Yes / No

Please list all allergies, including allergies to medicines.

Medication/Allergy	Type of reaction

SURGERIES:

Do you have any metal in your body from any previous surgeries? Yes / No

Please list previous surgeries

Surgery	Date	Details

SOCIAL HISTORY:

- a. Use of alcohol? Never Rarely Moderate Daily
- b. Use of tobacco? Never Previously, but quit (When?_____) Active (____packs/day x ____years)
- c. Use of recreational drugs (ie Marijuana)? None Some (Type/Frequency_____)
- d. Have you ever had a problem with dependency or abuse of prescription or non-prescription drugs? Y / N
If yes, please explain _____
- e. Have you ever been physically abused? Yes / No
- f. Have you ever been sexually abused? Yes / No

PAST MEDICAL HISTORY:

Please list ALL conditions you have had in the past

Condition	Age Diagnosed	Details

FAMILY MEDICAL HISTORY:

Please indicate blood relative with any illnesses or pain problems

Family Member	Age	Diseases/pain problems

DIAGNOSTIC STUDIES:

Please list all diagnostic studies you have had done. These can include x-rays, CT scans, MRIs, discograms, EMG/nerve conduction studies, etc.

Study (ex: MRI)	Body part	Date	Location (ex: St Francis)

REVIEW OF SYSTEMS:

Please mark the box next to the u have a history of or currently have:

Constitutional Symptoms:

<input type="checkbox"/>	Unexplained weight loss
<input type="checkbox"/>	Fever
<input type="checkbox"/>	Night sweats

Integumentary:

<input type="checkbox"/>	Change in skin color, hair, or nails
<input type="checkbox"/>	Change in temperature of extremities
<input type="checkbox"/>	Itching

Eyes:

<input type="checkbox"/>	Eye disease or injury
<input type="checkbox"/>	Wear glasses/contact lenses
<input type="checkbox"/>	Blurred vision
<input type="checkbox"/>	Glaucoma

Ear/Nose/Mouth/Throat:

<input type="checkbox"/>	Hearing loss
<input type="checkbox"/>	ringing in ears
<input type="checkbox"/>	Dry mouth
<input type="checkbox"/>	Chronic sinus problem or rhinitis

Cardiovascular:

<input type="checkbox"/>	Heart trouble
<input type="checkbox"/>	Chest pain or angina pectoris
<input type="checkbox"/>	Palpitations/murmurs
<input type="checkbox"/>	Fainting
<input type="checkbox"/>	Swelling of feet, ankles, or hands

Respiratory:

<input type="checkbox"/>	Chronic or frequent coughs
<input type="checkbox"/>	Shortness of breath

Gastrointestinal:

<input type="checkbox"/>	Nausea or vomiting
<input type="checkbox"/>	Frequent diarrhea
<input type="checkbox"/>	Constipation

<input type="checkbox"/>	Rectal bleeding or blood in stool
<input type="checkbox"/>	Abdominal pain
<input type="checkbox"/>	Peptic ulcer (stomach or duodenal)

Hematologic/Lymphatic:

<input type="checkbox"/>	Slow to heal after cuts
<input type="checkbox"/>	Bleeding or bruising tendency

Musculoskeletal:

<input type="checkbox"/>	Joint pain
<input type="checkbox"/>	Joint stiffness and/or swelling
<input type="checkbox"/>	Weakness of muscles or joints
<input type="checkbox"/>	Muscle pain
<input type="checkbox"/>	Difficulty in walking

Genitourinary:

<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	Bowel/Bladder incontinence

Neurological:

<input type="checkbox"/>	Progressive focal weakness
<input type="checkbox"/>	Numbness in groin
<input type="checkbox"/>	Numbness and/or tingling sensations

Psychiatric:

<input type="checkbox"/>	Memory loss or confusion
<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	Depression

Endocrine:

<input type="checkbox"/>	Heat or cold intolerance
<input type="checkbox"/>	Kidney stones or disease
<input type="checkbox"/>	Osteoporosis or vertebral fracture
<input type="checkbox"/>	Long term steroid use
<input type="checkbox"/>	History of IV drug use

Patient's Name:		Date:	
Drug Abuse Screening Test—DAST-10			
These Questions Refer to the Past 12 Months			
1	Have you used drugs other than those required for medical reasons?	Yes	No
2	Do you abuse more than one drug at a time?	Yes	No
3	Are you unable to stop using drugs when you want to?	Yes	No
4	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5	Do you ever feel bad or guilty about your drug use?	Yes	No
6	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7	Have you neglected your family because of your use of drugs?	Yes	No
8	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10	Have you had medical problems as a result of your drug use (eg. memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Guidelines for Interpretation of DAST-10		
Interpretation (Each "Yes" response = 1)		
Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	Encouragement and education
1-2	Low level	Risky behavior – feedback and advice
3-5	Moderate level	Harmful behavior – feedback and counseling; possible referral for specialized assessment
6-8	Substantial level	Intensive assessment and referral

Skinner HA. The Drug Abuse Screening Test. *Addictive Behavior*. 1982;7(4) 363-371.
 Yudko E, Lozhkina O, Feuts A. A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. *J Subst Abuse Treatment*. 2007;32:189-198.
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Interventional Pain Management, Spine Pain, Musculoskeletal Medicine, Electrodagnosis (EMG/NCS), Botox

CONTRACT FOR BUPRENORPHINE TREATMENT

As a participant in the buprenorphine protocol for treatment of Opioid abuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep, and be on time to all of my scheduled appointments.
2. I agree to conduct myself in a courteous manner while in the physician's office and with his staff.
3. I will not arrive at the office intoxicated or under the influence of drugs. If I do, the doctor will not see me, and I will not be given any medication until my next scheduled appointment.
4. I will not sell, share or give any of my medications to another individual. I understand that such mishandling of my medication is a serious violation of this contract and would result in my treatment being terminated.
5. I will not deal, steal or conduct any illegal or disruptive activities in the physician's office.
6. I agree that the prescription I receive can only be given to me at my regularly scheduled office visits. If I miss an appointment I will not receive my prescription until I am seen by the physician.
7. I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost/stolen medication will not be replaced regardless of the reason for loss.
8. I agree not to obtain medications from any physicians, pharmacies, or other sources without informing my treating physician. I understand that mixing buprenorphine with other medications, especially benzodiazepines such as vallium and other drugs of abuse can be dangerous.
9. I agree to take my medication as my physician has instructed and not to alter the way I take my medication without first consulting my physician.
10. I understand that medication alone is not sufficient treatment for my disease, and I agree to participate in the patient education and relapse prevention programs, as provided, to assist in my treatment.

Printed Name

Signature

Date

Tulsa: 9308 S. Toledo Ave • Tulsa, OK 74137 • Phone 918.728.8020 • Fax 918.728.8019
Bartlesville: 3550 S.E. Frank Phillips Blvd • Bartlesville, OK 74006 • 918.728.8020 • Fax 918.728.8019
Stillwater: 1815 W. 6th Ave • Stillwater, OK 74074 • 918.728.8020 • Fax 918.728.8019

PRIVACY NOTICE

Dear Patient or Representative:

We are committed to protecting the privacy of your medical information. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. This Notice describes your rights and our legal duties regarding your Protected Health Information (PHI). Protected Health Information means any information about you that identifies you or for which there is a reasonable basis to believe the information can be used to identify you.

HOW OKLAHOMA INTERVENTIONAL SPINE & PAIN MAY USE OR DISCLOSE YOUR MEDICAL INFORMATION:

1. We will use your medical information to treat you. For example, if there is any follow-up care such as home health services, etc. We may also disclose your medical information to people outside our office that are involved in your care such as your family members, referring physicians, pharmacist, etc.
2. We may use and disclose your medical information to receive payment for our services from you, and insurance company or a third party. For example, we may need to give your health plan information about a procedure we perform at our office so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
3. We may share your medical information with our business associates. We have a written contract with each business associate that contains terms requiring them to protect the confidentiality of your medical information.
4. Any other uses and/or disclosures of your medical information will be made only with authorization. Your authorization may be revoked, but must be communicated in writing.

DESCRIPTION OF YOUR MEDICAL INFORMATION RIGHTS:

1. You have the right to inspect and copy medical and billing records that we maintain. You must submit your request in writing. By Oklahoma statute, we currently charge \$1.00 for the first page and \$0.50 each additional page plus postage costs.
2. You have the right to request an amendment to the medical information we have about you if you believe it is incomplete or incorrect. To request an amendment, your request must be made in writing; include a reason for your request, and it will be submitted to the privacy officer. We may deny your request for an amendment for the following reasons: it is not in writing; does not include a reason; the information was not created by us; is not a part of the medical information kept by our practice; is not part of the information which you are permitted to inspect a copy; or in our judgment, the information will be acted on no later than sixty days after its receipt.
3. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, we will only contact you at work, home, by mail, phone, answering machine, etc. Your request must be specific and in writing to the privacy officer in our office.
4. You have the right to request a list of the disclosures we have made of your medical information. To request this list, you must submit your request in writing to this office. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request must state a time period no longer than six years. The first copy of the list is free, but each additional request may invoke a fee.
5. You have the right to request a restriction on the information we use or disclose for treatment, payment, or health care. Information for treatment or health care operations we are not required to agree to the restriction and reserve the right to immediately withdraw our services from you and terminate the relationship.
6. You have the right to receive a paper copy of this Privacy Notice.

For more information or to report a problem you may contact the Oklahoma Interventional Spine & Pain Privacy Office, 9308 S Toledo Avenue, Tulsa, OK 74137. If you believe your privacy rights have been violated, you may file a complaint with the Privacy officer or the Secretary of the Department of Health and Human Services. All complaints must be in writing. There will be no retaliation by Oklahoma Interventional Spine & Pain if you file a complaint.

We reserve the right to change or amend this Privacy Notice at any time in the future. Revised copies will be available to you.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

Oklahoma Interventional Spine & Pain

9308 S. Toledo Avenue

Tulsa, OK 74137

918-728-8020

A complete description of how your medical information will be used and disclosed by Oklahoma Interventional Spine & Pain is in our "Privacy Notice", which you should read before signing this acknowledgment.

I hereby certify that I have read the "Privacy Notice" for "Oklahoma Interventional Spine & Pain".

Patient or representative

Date signed

Brandon Claflin D.O
*Board Certified, Physical
Medicine & Rehabilitation
Medicine*



Okspinepain.com

interventional Spine Pain Management. Electrodiagnosis (EMG, Nerve Conduction Studies), Workers Compensation Injuries

HIPAA RELEASE OF PROTECTED HEALTH INFORMATION

Patient Signature. _____ Date: _____

Please provide us with a list of names of whom you would allow our office to release OR discuss medical information.

Information may be released to the following individuals:

Name: _____ Relationship to patient. _____

Name: _____ Relationship to patient. _____

Name: _____ Relationship to patient _____