Aultman Alliance Community Hospital Therapeutic Contract

To receive care and treatment at Aultman Alliance Pain Management, I understand and will comply with the following rules and expectations:

1. I agree to help myself by trying to change my behavior towards a healthier lifestyle including but not limited to: stop smoking, use of alcohol only in moderation as permitted by my provider, diet and weight control and exercise. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

2. I will not be disruptive, verbally or physically abusive, or uncooperative with the AACH Pain Center staff or provider. Such action may result in my discharge from the AACH Pain Center.

3. I will obtain all my prescriptions for pain management from the provider at the AACH Pain Center. If I am given any pain medication from another provider, I will notify the AACH Pain Center within 24 hours. This includes treatment and/or medications received from emergency room visits.

4. If medication is part of my treatment, I understand that all prescriptions are monitored very closely. I understand that:

I will only be given a prescription if my provider decides that medication is part of my treatment.
I will use all medication as prescribed and only for the reason ordered.
I WILL NOT stop any medication suddenly. I WILL NOT use my medication for any other reasons than those prescribed by provider. These actions may result in my dismissal from the AACH Pain Center.
I will not use more of my medication than the amount prescribed by my provider. I will call and schedule an appointment to discuss any medication changes or adjustments. I understand that no medication changes are made over the phone.
I will not use any illegal substances, street drugs, or abuse alcohol while taking my prescribed medications. I will not take any medications, including opioids, prescribed for other people. I will not share my medications with others.
I will not be involved in the sale, illegal possession, diversion, or transportation of any controlled substances, including opioids, sleeping pills, or nerve pills.
I understand that the AACH Pain Center will be the only source for medication to treat my pain. I will not seek pain medication from any other persons, hospital, or health care provider. If I need any medication for surgery or post-operative pain (or other conditions such as dental work, broken bones, or other acute medical conditions) I will discuss it with my provider in advance and a special plan will be agreed upon.
I agree to use ONLY one pharmacy, _____ tel #_____
For filling my medication prescriptions including opioids.
It is MY responsibility to protect my medications from any loss, theft, or damage. I understand that a police report may be requested if any of medication is stolen. I understand that filing of the police report does not guarantee my provider will replace my medication
I will not change or alter a prescription given to me by my provider. I understand that changing or altering my prescription is a criminal offense and will result in my immediate discharge from the AACH Pain Center. I understand that the AACH Pain Center may report any criminal action by me to the appropriate authorities and the police.

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I understand that my provider reserves the right to perform random or unannounced oral or urine drug testing and/or pill counts. If the staff or provider requests a urine sample or pill count, I agree to cooperate. If I decide not to provide a urine sample or my medication for a pill count, the provider may change my treatment plan, including the safe discontinuation of any opioid medications or termination of my treatment at the AACH Pain Center. The presence of non-prescribed drugs, illegal street drugs or the absence of prescribed medication in urine may be grounds for termination of treatment.

I understand that I may experience side effects with opioid medications, which may include but are not limited to: skin rash, constipation, sexual dysfunction, sleeping abnormalities, swelling, sweating, impaired mental status, drowsiness, and/or impaired motor ability. I further understand that overuse of opioids may cause slow breathing or even death. I will notify the staff or provider of any side effect.
I understand that physical dependence, addiction and/or tolerance may occur with the use of opiod medications.

- PHYSICAL DEPENDENCE means that if a medication is abruptly stopped or not taken as directed, withdrawal symptoms can occur. This is a normal physiological response. Withdrawal symptoms for opioid medication include but are not limited to: sweating, nervousness, abdominal cramps, diarrhea, goose bumps, changes in mood, or death. Physical dependence does not equal addiction. For example, a person can be dependent on insulin to treat diabetes, but that person is not addicted to the insulin.
- ADDICTION is a primary, chronic disease with a compulsive need for and use of habit forming substances.
- TOLERANCE is the body's ability to become adjusted to something so effects are less strong.

ALL NARCOTICS CAN LEAD TO RESPIRATORY PROBLEMS, ADDICTIONS, AND/OR DEATH.

While being treated with pain medication, close monitoring of the medication is required. Therefore, all scheduled appointments must be kept. I will meet regularly with my prescribing provider. If an appointment is cancelled with less than 24 hours notification, no medications will be prescribed until I see the provider. If 3 consecutive appointments are missed, at the discretion of the provider, no further appointments may be scheduled.

I am responsible for keeping track of the medication for refills so that I will not run out of my prescription. All refills of prescriptions will be completed at the time of the office visit. **NO REFILLS WILL BE DONE OVER THE PHONE.**

ANY VIOLATION OF THE ABOVE GUIDELINES MAY RESULT IN DISCONTINUATION OF THE PRESCRIBED MEDICATION AND DISCHARGE FROM THE AULTMAN ALLIANCE COMMUNITY HOSPITAL CENTER FOR PAIN MANAGEMENT CARE.

I AFFIRM THAT I HAVE THE FULL RIGHT AND POWER TO SIGN AND BE BOUND BY THE AGREEMENT AND THAT I HAVE READ, UNDERSTAND, AND ACCEPT ALL THE TERMS OF THE CONTRACT.

Signature: _____ Date: _____

• 200 East State Street / Alliance, OH 44601
• Phone: 330-596-6000 / www.aultmanalliance.org

THRPTC CNTRCT

_____ Date of Birth ____/_____/_____
Last Name First Middle (as appears on insurance card)

Address _____ City _____ State _____ Zip code _____

Home Phone # _____/_____/_____ Cell Phone # _____/_____/_____ Pharmacy _____

Patient's Email: _____ (for your portal access only)

Social Security # _____/_____/_____ Ethnicity: (check one) [ ] Not Hispanic or Latino [ ] Hispanic or Latino

Gender: _____

Race: (circle) White Black / African American Bi-Racial American Indian/ Alaska Native Asian
Native Hawaiian/ Pacific Islander
Preferred language: _____ (English, Spanish, Other- please list) Primary Care Physician _____

Marital Status: (please circle) Married Widowed Divorced Single Separated
Patient's Employer _____ Phone _____/_____/_____

Guarantor (name to whom statements are sent) _____ DOB_____/_____/_____
Last Name First Name Middle Init
Address (if different than above) _____
Street City State Zip code
Phone: _____/_____/_____
DO NOT LEAVE BLANK UNLESS YOU DO NOT HAVE INSURANCE SELF PAY _____(CHECK)
Policyholder Name _____ Date of Birth _____ SS # _____
Phone _____/ _____/ _____
Patient's Relationship to Policyholder (check one) ____ Self ____ Spouse _____ Dependent

Secondary Insurance Name _____ Member I.D. # _____ Group # _____
Policyholder Name _____ Date of Birth _____ SS # _____
Phone _____/ _____/ _____
Patient's Relationship to Policyholder (check one) ____ Self ____ Spouse _____ Dependent

ADDITIONAL CONTACT INFORMATION: ***Please give the name and phone number of a responsible person that you give permission for our office to discuss medical information, test results, or to contact in case of an emergency.***

1. _____
Name Relationship Phone #

I am authorizing treatment for the above patient. This treatment may include administration of medications, diagnostic testing and X-ray examinations, or other treatment as deemed necessary by the attending physician. I authorize the release of any medical or other information necessary to process claims on my behalf. I authorize my insurance benefits (including authorized Medicare benefits, if applicable) be paid directly to Alliance Community Medical Foundation (ACMF) for any services furnished. To provide continuity of care, I authorize the release of medical information to specialty physicians under contract with ACMF. I acknowledge that I have been notified that the Notice of Privacy Practices of Aultman Health Foundation (AHF) has been revised effective 9/2019, which sets forth the ways in which my protected health information may be used or disclosed by AHF, and outlines my rights with respect to such information. I have been provided the opportunity to request a paper copy of this notice as well as information on how to view the notice electronically on the website at ***www.aultmanalliance.org.***

Signature: _____ Date: _____ _____
Relationship if not signed by patient

May we leave a message on answering machine or with the person answering; concerning
Results of tests (circle) Yes No **Appointments** (circle) Yes No **Consent to text alerts** Yes No
I give permission for ACMF Physicians to obtain my medication history, benefits, and formulary information from my pharmacy on file. Yes No
12/2019

AULTMAN
ALLIANCE COMMUNITY HOSPITAL

Appointment/Cancellations/No Show Policy

Appointments

Office visits are by appointment only. Please arrive 15 minutes early for your appointment. Patients who are late for any appointment may be asked to reschedule at the physician's discretion.

Remember to bring all your prescriptions, over-the-counter medicines, vitamins and supplements to each office visit. This will enable your doctor to review the medications at each visit.

Cancellations

If you are unable to keep an appointment, we ask that you cancel at least 24 hours in advance. If this is not possible, please call as soon as you can so that another patient can be given your appointment time.

Missed Appointments (Non-cancelled)

We understand that occasional missed appointments can occur for a variety of reasons. When you miss an appointment without cancelling, someone else who could have been seen in your place is delayed unnecessarily.

We track missed (non-cancelled) appointments. A "No Show/Late Cancellation" is defined as missing an appointment without cancelling at least 24 hours before scheduled time. There will be a charge of $25.00 applied to your account following the second missed or non-cancelled appointment. Insurance will not cover charges for no show/late or late cancellation fees. This charge is in addition to any other charges you may have incurred. Repeated missed appointments may result in your physician sending a letter discharging you from the practice. We will offer 30 days of emergent care only and transfer your medical records when you find a new physician.

I have read and understand the above policy for Alliance Community Medical Foundation Appointment/Cancellations/No Show Policy.

Patient Signature: _____

Date: _____

For Chart Purposes:
Apt. 1-Date:_____ Apt. 2-Date:_____ Apt. 3-Date:_____

ACMF-09-QP 11109

Financial Policy

Thank you for choosing Alliance Community Medical Foundation for your healthcare needs. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. We have adopted the following financial policies to help reduce confusion and misunderstanding.

All patients must read and sign this form prior to receiving services.

Payment of patient obligations is due at the time of service. We accept cash, check, credit and debit cards.

Insurance

- It is your responsibility to provide us with your most current insurance information for each visit. If you fail to provide accurate insurance information, your insurance may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
- We participate in most health insurance plans, including Medicare and Medicaid. If you are not insured, payment in full is expected at each visit. If you are insured by a plan we do business with but you do not have an up-to-date insurance card, payment in full for each visit is required until you can provide a valid insurance card. If you are insured by a plan we do not do business with we will file a claim as a courtesy however you may be responsible for any balance remaining.
- Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract. Knowing your insurance benefits is your responsibility.
- We contract with most plans; however we may not be in network with your particular plan. It is your responsibility to verify that the physician you have an appointment with is covered under your plan in network benefit.
- Please be aware that some or perhaps all of the services you receive may be non-covered or not considered reasonable and necessary by Medicare or other insurers. You are financially responsible for services not covered by your insurance company.
- If you have an insurance plan which we participate with, we will submit your claims to the insurance plan and assist you in any way we reasonably can to help get your claims paid. Your insurance plan may need you to supply certain information directly. It is your responsibility to comply with their request; any failure to comply with said request will results in the transfer of the claim to the responsibility of the patient. The balance of your claim is your responsibility whether or not your insurance company pays your claim.
- Co-payments and any outstanding account balances are due at the time of service. You are responsible for paying the full amount determined by your insurance company once they have paid your claim-regardless of our estimation.

Self Pay

- Patients with no insurance coverage or patients without an insurance card on file are expected to pay at the time services are rendered. Once charges are determined, you will receive a statement for any remaining balance.

Billing

- You will receive a statement (sent to the billing address you provide) notifying you of any balance you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact Physician Billing (330-596-7060) within 30 days of receipt of the statement.
- Payment is expected in full upon receipt of the statement. Payment shall be paid on line or sent to the address listed on the statement. If you are unable to pay the balance in full, you must contact Physician Billing to establish a payment schedule. If you fail to set up a formal payment schedule you may continue to receive payment reminder calls.

Failure to keep your account current or make payment arrangements may result in you not being able to receive services in our offices. Please be aware that if a balance remains unpaid, and no formal payment schedule exists regardless of consecutive monthly payments, your account will be referred to a collection agency and you and your immediate family members may be discharged from the practice. In addition, a collection agency may take additional steps to collect the balance, which may include reporting to credit bureaus.

I hereby acknowledge that I have read this document and understand my financial responsibility for services provided, and agree to abide by the above guidelines.

COPY AVAILABLE ON LINE THROUGH YOUR ATHENAHEALTH PATIENT PORTAL

_____	_____/_____/_____	_____
Signature of Patient / or Legal Guardian	Date	Relationship to Patient (if applicable)

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Center for Pain Medicine

Pain Questionnaire

Name: _____ DOB: _____
Referring Physician: _____ Primary Physician: _____
Was an accident involved? Yes / No Describe: _____
Is this a work related injury? Yes / No Employer Name: _____
Is there an active Workers Compensation claim or disability compensation related to your injury? No / Yes
Date of injury: _____ Claim #: _____
Do you have any legal claims pending in regards to your injury: No / Yes Height: _____ Weight: _____

PAIN INTENSITY Location: _____ How long: _____

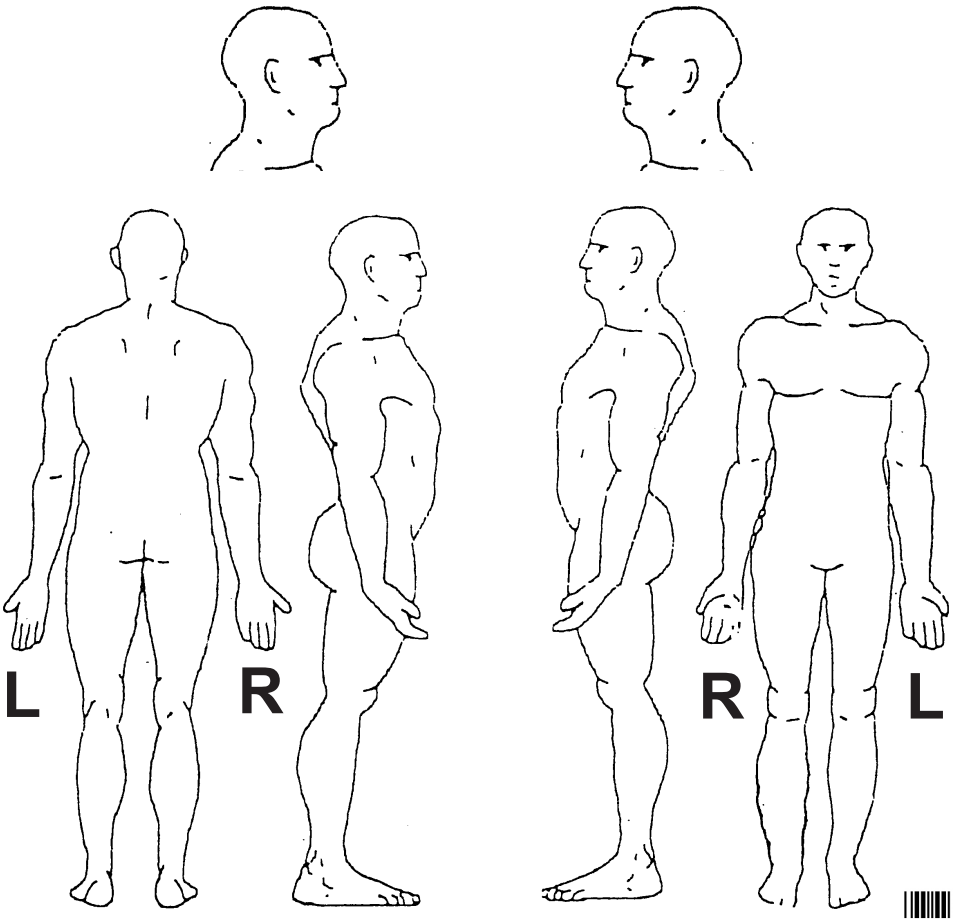
Mark the level of your pain using a 0 - 10 Pain Scale (0 - no pain, 10 - worst pain)

Present: _____
Worst pain gets: _____
Best pain gets: _____

Circle your present level of pain

0 1 2 3 4 5 6 7 8 9 10
No Pain Moerate Pain Worst Possible

What is the quality of your pain?
prick / ache / burn / dull / throb / sharp / other _____
What makes the pain worse? _____
What makes the pain better? _____
Does your pain effect your activities of daily living? No / Yes
sleep / appetite / physical activity / emotions / other _____



PAIN QSTN

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Center for Pain Medicine

Pain Questionnaire

History and Review of Systems

Head and Neck

Hearing Loss	( ) Yes ( ) No
Vision problems	( ) Yes ( ) No
Difficulty Swallowing	( ) Yes ( ) No
Difficulty Speaking	( ) Yes ( ) No

Heart

Heart Disease	( ) Yes ( ) No
High Blood Pressure	( ) Yes ( ) No
Congestive Heart Failure	( ) Yes ( ) No

LUNG

Asthma	( ) Yes ( ) No
COPD	( ) Yes ( ) No
Emphysema	( ) Yes ( ) No

STOMACH

Acid Reflux	( ) Yes ( ) No
Hepatitis	( ) Yes ( ) No
Cirrhosis	( ) Yes ( ) No
Ulcers	( ) Yes ( ) No

NERVOUS SYSTEM

Seizures	( ) Yes ( ) No
Multiple Sclerosis	( ) Yes ( ) No
Migraines	( ) Yes ( ) No
Strokes	( ) Yes ( ) No
Fibromyalgia	( ) Yes ( ) No

HORMONAL

Diabetes	( ) Yes ( ) No
Thyroid disease	( ) Yes ( ) No

SKIN

Rashes or Bruising ( ) Yes ( ) No

SURGERIES

_____

_____

_____

HEMATOLOGIC/ LYMPH

Cancer	( ) Yes ( ) No
Anemia	( ) Yes ( ) No

BONES/MUSCLE

Arthritis	( ) Yes ( ) No
Rheumatoid Arthritis	( ) Yes ( ) No

OTHER

Liver Disease	( ) Yes ( ) No
Kidney Disease	( ) Yes ( ) No
Dialysis	( ) Yes ( ) No
Hemo or peritoneal_____	
Immunizations up to date	( ) Yes ( ) No
Exposed to communicable Disease	( ) Yes ( ) No
Been to pain clinic before	( ) Yes ( ) No

SOCIAL

Anxiety/Depression	( ) Yes ( ) No
Smoke	( ) Yes ( ) No
Alcohol	( ) Yes ( ) No
Drug use	( ) Yes ( ) No
Pregnant	( ) Yes ( ) No

FAMILY HISTORY

	Mother	Father
Heart Disease	_____	
Lung Disease	_____	
Cancer	_____	
Strokes	_____	
Other	_____	

Any surgeries, injections or physical therapy for pain _____

PAIN QSTN

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Center for Pain Medicine

Pain Questionnaire

Medication Use

Name	Dosage	Frequency/Times/Day

Allergies: _____

_____

_____

PAIN QSTN