Orthopedic Specialties
of Spartanburg

# *Welcome*

Welcome and thank you for choosing Orthopedic Specialties of Spartanburg for your care. OSS is dedicated to providing the best possible care and service to our patients. Please bring the following items with you to your appointment

- New Patient Paperwork
- Insurance card(s)
- Driver's License or Picture ID
- Any MRI, X-rays or any other scan studies with reports pertinent to your current problem

*Please fill out all paperwork prior to arrival to avoid appointment delays.*

## Referrals

Some insurance plans such as HMOs require a referral from your primary care physician. If your plan requires a referral it is the patient's responsibility to make sure OSOS receives this referral prior to being seen. Any claims denied due to lack of referral will be the patient's responsibility.

## Payment Policy

We regard the patient's prompt handling of financial obligations as essential to ensure we can provide quality service.

**Payment Options if you have insurance:** OSS has made prior arrangements with most insurance companies to accept assignment of benefits. We will file a claim with all insurance companies we participate with. Unreported changes in medical insurance could result in billing delays, rejections, and personal financial responsibility of services rendered.

**Financial Responsibilities:**

- Your deductible, copay and any determined out of pocket will need to be paid at the time of service. Unpaid co-pays may be reported to your insurance company since this is a requirement of your insurance plan and may affect your insurance benefits.
- Bring your current insurance information to each visit. Failure to provide complete and accurate insurance information may result in patient financial responsibility for the entire bill. It is your responsibility to understand your insurance benefits to include deductible amounts.
- In the event that your health plan considers the service to be a “non-covered” service you will be financially responsible for the charge at the time of service.
- Failure to meet your financial obligation to OSS could result in further actions.
- OSS will refund over payments when all services have been processed by insurance and care is complete. Refunds for $25.00 or less is refunded upon request

**Payment Options if you are uninsured:** Payment is expected on the day treatment is rendered. We accept cash, check, Visa, Mastercard, Discover or American Express. Alternate payment plans are available for those who qualify. You may inquire about this with an OSS financial representative.

**Minors:** The parent or guardian is responsible for payment. Minor must be accompanied by a parent or legal guardian to receive treatment.

## MRI Cancellations and Missed Appointments

Appointments for MRIs need to be canceled 24 hours in advance. If you fail to cancel in the appropriate time frame or “no-show” for an appointment you will be charged $50.00 for missed appointments.

**Disability Forms**

Disability forms are processed in the order they are received. Allow 7-10 business days for completion. There is a $25.00 processing fee for disability forms. Multiple forms brought on the same day will be charged $25.00 for the first form and $5.00 for each additional form.

**Hours of Operation**

Orthopedic Specialties is open M-F 8:00 am to 5:00 pm with exceptions for holidays. Closures due to inclement weather will be posted on WYFF and WSPA and you will be contacted to reschedule your appointment. If you have a medical emergency when our clinic is closed dial 911. If you have a non-life threatening urgent health concern that cannot wait until normal business hours you may call our answering service by dialing our office number, 864-208-8800.

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❑ ***I have read the above patient information and I agree to adhere to these policies.***

Patient Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____

303 East Wood Street
Spartanburg, SC 29303

Orthopedic Specialties
of Spartanburg

Phone (864) 208-8800
Fax (864) 208-8857
www.orthopedicspecialties.com

## Section I Patient Information

Name _____ Birth Date _____ SS# _____

Street Address _____ What is your preferred Language? _____

Mailing Address _____

City/State/Zip _____

Home Phone _____ Cell Ph# _____ Work Ph# _____

Email _____ Employer _____

Please check approved methods of contact: ☐ Phone/Voicemail ☐ Web Portal ☐ Email Which is your preferred method of contact: _____

Employer's Address _____

City, State, Zip _____

Nursing Home: ☐ YES ☐ NO Nursing Home Name/Ph.# _____

## Section II Responsible Party (Fill out this section if the patient is a minor or has a legal guardian)

Responsible Party Name _____ SS# _____

Relationship to Patient _____ Employer _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____

## Section III Emergency Contact (Please give someone outside your immediate family)

Contact Name _____ Relationship _____ Phone _____

Address _____ City/State/Zip _____

## Section IV Insurance Information (YOU MUST FURNISH COPIES OF ALL INSURANCE CARDS)

### Primary Insurance Information

**Insurance Co. Name**

**Relationship of Pt. to Insured (Circle One)** ☐ **Spouse** ☐ **Child** ☐ **Other**

**Insured Name**

**Policy/I.D # - Group #**

**Insured SS#**

**Insured Birth Date**

**Insured Employer**

### Secondary Insurance Information

**Insurance Co. Name**

**Relationship of Pt. to Insured (Circle One)** ☐ **Spouse** ☐ **Child** ☐ **Other**

**Insured Name**

**Policy/I.D # - Group #**

**Insured SS#**

**Insured Birth Date**

**Insured Employer**

## Insurance Authorization and Assignment

I hereby authorize Orthopedic Specialties of Spartanburg, LLC to furnish information to insurance carriers and referring physicians concerning my illness and treatment, and I hereby assign to the physicians all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I certify that all information provided here is correct to the best of my knowledge.

Date _____ **Signature of Patient** X _____

# PATIENT HISTORY

Patient Name _____ Date of Birth _____ Age _____

**Reason for Visit:** _____

_____

_____

_____

**ACCIDENT DETAILS**

Was this an accident: Yes ❑ Date of Accident _____ No ❑ Skip to Non-Accident Details below.

Type of Accident: Work ❑ Employer _____ Home ❑ Auto ❑

If Auto, were seat belts worn? ❑ Yes ❑ No Were you the driver? ❑ Passenger? ❑

Sport - School Name _____ Which Sport _____ ❑Other _____

How did accident happen: _____

Where did accident happen: _____

Do you have an attorney: Yes ❑ No ❑ If yes, Attorney Name _____

**NON ACCIDENT DETAILS**

How/When/Why did problem start: _____

Was onset: Gradual ❑ Sudden ❑ Is Problem: Constant ❑ Intermittent ❑

Have you been treated for the same / similar problem? Yes ❑ By whom _____ No ❑

Were you seen in the ER or Urgent Care? Yes ❑ Where _____ No ❑

Have you had X-rays for this problem? Yes ❑ Where _____ When _____ No ❑

Have you had an MRI for this problem? Yes ❑ Where _____ When _____ No ❑

Are you out of work due to this problem: Yes ❑ Last Date Worked _____ No ❑

What medications have you taken or been prescribed specifically for this problem: _____

*Do not write, stamp, punch holes or affix a sticker in this area. To reproduce, follow the printing instructions. Do not fold this form.*

Direction of Feed

# Patient History

Please answer every question

***STAFF:*** *Handwritten items must be entered* ***MANUALLY.***

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

## Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

**What is your height?**

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Feet | 3 | | 4 | | 5 | | 6 | | 7 | | | | | | | | | | |
| Inches | 1 | | 2 | | 3 | | 4 | | 5 | | 6 | | 7 | | 8 | | 9 | | 10 | | 11 | |

**What is your weight?**

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 100 | | 200 | | 300 | | 400 | | 500 | | 600 | | | | | | | | | | | |
| Pounds | 10 | | 20 | | 30 | | 40 | | 50 | | 60 | | 70 | | 80 | | 90 | | | | | |
| | 1 | | 2 | | 3 | | 4 | | 5 | | 6 | | 7 | | 8 | | 9 | | | | | |

**EXAMPLE**
If you weigh 222 pounds, you would fill in the ovals like this: 200, 20, 2

**Are you:** right handed ◯ left handed ◯ ambidextrous ◯

**Gender:** male ◯ female ◯

**If female, are you pregnant?** yes ◯ no ◯ unknown ◯

**Primary Care Physician:** _____ **Who referred you?** _____

## PAST MEDICAL HISTORY

**Please indicate if you have a history of the following. Mark all that apply.**

- ◯ Acid Reflux
- ◯ Adverse Reaction to Anesthesia (Type of Reaction): _____
- ◯ Alzheimer's (Significant Memory Loss)
- ◯ Anemia
- ◯ Angina or Chest Pain
- ◯ Asthma
- ◯ Atrial Fibrillation (Erratic Heartbeat)
- ◯ Bladder Problems
- ◯ Bleeding Ulcers
- ◯ Blood Clot ◯ legs ◯ lungs
- ◯ Congestive Heart Failure
- ◯ Coronary Artery Disease
- ◯ Dental Disease
- ◯ Depression
- ◯ Diabetes
- ◯ Emphysema
- ◯ Epilepsy / Seizures
- ◯ Fibromyalgia
- ◯ Gout
- ◯ Hemophilia (Excessive Bleeding)
- ◯ Hepatitis
- ◯ High Blood Pressure (Hypertension)
- ◯ High Cholesterol
- ◯ HIV / AIDS
- ◯ Kidney Disease
- ◯ MRSA
- ◯ Osteoarthritis
- ◯ Osteoporosis
- ◯ Pneumonia
- ◯ Psychiatric Disorder
- ◯ Rheumatoid Arthritis
- ◯ Sickle Cell
- ◯ Sleep Apnea ◯ CPAP Machine
- ◯ Stroke (CVA)
- ◯ Thyroid Disease
- ◯ Breast Cancer
- ◯ Cervical Cancer
- ◯ Colon Cancer
- ◯ Liver Cancer
- ◯ Melanoma Skin Cancer
- ◯ Non-Melanoma Skin Cancer
- ◯ Ovarian Cancer
- ◯ Pancreatic Cancer
- ◯ Prostate Cancer
- ◯ Rectal Cancer
- ◯ Stomach Cancer
- ◯ Thyroid Cancer
- ◯ Uterine Cancer
- ◯ Other Type(s) of Cancer: _____
- ◯ Other Not Listed (explain): _____
- ◯ **NO SIGNIFICANT MEDICAL HISTORY**

## SURGICAL HISTORY

**Please indicate if you have had any of the following surgeries. Mark all that apply.**

- ◯ **I HAVE HAD NO SURGERIES**
- ◯ Aneurysm
- ◯ Angioplasty / Stents
- ◯ Artery Bypass of Arm or Leg
- ◯ Carotid
- ◯ Coronary Bypass (CABG)
- ◯ Heart Valve Replacement
- ◯ Pacemaker / Defibrillator
- ◯ Prostate

**ABDOMINAL SURGERIES**

- ◯ Appendectomy
- ◯ Capsule Endoscopy
- ◯ Gallbladder Removal
- ◯ Colon
- ◯ Colonoscopy
- ◯ Colostomy
- ◯ Gastrectomy
- ◯ Gastric Bypass
- ◯ Gastric
- ◯ Hemorrhoidectomy
- ◯ Hernia Repair (hiatal)
- ◯ Hernia Repair (inguinal)
- ◯ Hernia Repair (umbilical)
- ◯ Hysterectomy
- ◯ Pancreatic
- ◯ PEG Tube Placement
- ◯ Removal of Intestinal Adhesions
- ◯ Fallopian Tube Removal (Salpingectomy)
- ◯ Small Bowel Resection
- ◯ Large Bowel Resection
- ◯ Stomach Resection
- ◯ Liver Resection
- ◯ Whipple
- ◯ Splenectomy

**Continued on next page...**

## SURGICAL HISTORY continued...

### BONE / JOINT SURGERIES

| | left | right | both |
|---|---|---|---|
| Ankle | ◯ | ◯ | ◯ |
| Arm | ◯ | ◯ | ◯ |
| Foot | ◯ | ◯ | ◯ |
| Hand | ◯ | ◯ | ◯ |
| Hip | ◯ | ◯ | ◯ |
| Leg | ◯ | ◯ | ◯ |
| Knee | ◯ | ◯ | ◯ |
| Shoulder | ◯ | ◯ | ◯ |
| Wrist | ◯ | ◯ | ◯ |

◯ Lumbar Spine
◯ Cervical Spine

### BREAST SURGERY

◯ Breast Biopsy
◯ Breast Removal
◯ Breast Reduction
◯ Breast Reconstruction
◯ Cosmetic Breast Surgery

**OTHER SURGERY NOT LISTED ABOVE** (please specify):

## FAMILY MEDICAL HISTORY

**Please indicate which family member(s) have had these illnesses:**

◯ **Family History UNKNOWN** ◯ **ADOPTED** ◯ **NO SIGNIFICANT FAMILY MEDICAL HISTORY**

| | Parent | Grandparent | Brother or Sister |
|---|---|---|---|
| Adverse Reaction to Anesthesia | ◯ | ◯ | ◯ |
| Bleeding Disorders | ◯ | ◯ | ◯ |
| Blood Clots (Pulmonary Embolism) | ◯ | ◯ | ◯ |
| Cancer | ◯ | ◯ | ◯ |
| Depression | ◯ | ◯ | ◯ |
| Diabetes | ◯ | ◯ | ◯ |
| Heart Disease | ◯ | ◯ | ◯ |
| Hypertension (High Blood Pressure) | ◯ | ◯ | ◯ |
| Osteoarthritis | ◯ | ◯ | ◯ |
| Osteoporosis | ◯ | ◯ | ◯ |
| Rheumatoid Arthritis | ◯ | ◯ | ◯ |
| Stroke | ◯ | ◯ | ◯ |

**OTHER SIGNIFICANT FAMILY HISTORY** (please specify condition and family member):

## SOCIAL HISTORY

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Marital status:** | single ◯ | married ◯ | partnered ◯ | divorced ◯ | widowed ◯ | | | | | |
| **Smoking status:** | never ◯ | in the past ◯ | current (some days) ◯ | current (every day) ◯ | | | | | | |
| **If yes, packs per day** (now or in the past): | <½ ◯ | ½ ◯ | 1 ◯ | 1 ½ ◯ | 2 ◯ | >2 ◯ | | | | |
| **Do you dip or chew tobacco?** | never ◯ | in the past ◯ | currently ◯ | | | | | | | |
| **If yes, cans per week** (now or in the past): | <1 ◯ | 1 ◯ | 2 ◯ | 3 ◯ | 4 ◯ | >4 ◯ | | | | |
| **Do you drink alcoholic beverages?** | never ◯ | in the past ◯ | currently ◯ | | | | | | | |
| **If yes, how many drinks per week?** | only on special occasions ◯ | 1-7 ◯ | 8-14 ◯ | >14 ◯ | | | | | | |
| **Do you use recreational drugs?** | never ◯ | in the past ◯ | currently ◯ | | | | | | | |

Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

# Review of Systems

Please answer every question

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

## Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

## Mark only the symptoms that you are experiencing CURRENTLY.

**Mark all that apply ---- if no symptoms, please mark "NONE."**

| | | | |
|---|---|---|---|
| **General** | frequent fever | weight loss<br>weight gain | NONE |
| **Eyes** | blurred vision | double vision<br>impaired vision | NONE |
| **Ear, Nose, and Throat** | hoarseness | hearing loss<br>trouble swallowing | NONE |
| **Cardiovascular** | chest pain | palpitations | NONE |
| **Respiratory** | shortness of breath | chronic cough | NONE |
| **Gastrointestinal** | vomiting<br>loss of appetite<br>stomach pain with anti-inflammatory | reflux<br>nausea<br>blood in stool | NONE |
| **Genitourinary** | painful urination<br>excessive urination | blood in urine<br>kidney problems<br>irregular periods | NONE |
| **Breast** | | breast lumps | NONE |
| **Skin** | rash | skin ulcer<br>psoriasis | NONE |
| **Neurological** | headache | sleep disorder<br>dizziness | NONE |
| **Musculoskeletal** | muscle weakness | fibromyalgia | NONE |
| **Psychiatric** | anxiety | bipolar<br>depression | NONE |
| **Endocrine** | excessive thirst | cold intolerance<br>heat intolerance | NONE |
| **Heme / Lymphatic** | anemia<br>prior blood transfusion | easy bleeding<br>easy bruising | NONE |

Orthopedic Specialties
of Spartanburg

**If you have not had one of the immunizations listed, please type NO on the month line.**

# PATIENT MEDICATION LIST

Date: _____

| Name: | Phone Number(s): |
|---|---|
| Street Address: | |
| City/State: | |

## IMMUNIZATION RECORD

| | | |
|---|---|---|
| Tetanus **Month_____ Year_____** | Flu Vaccine **Month_____ Year_____** | Pneumonia Vaccine **Month_____ Year_____** |
| Shingles **Month_____ Year_____** | Other | |

## ALLERGIES

| ALLERGIC TO/DESCRIBE REACTION | ALLERGIC TO/DESCRIBE REACTION |
|---|---|
| **If no Allergies check this box!!** ☐ | |
| | |
| | |
| **Metal Allergy: (ex. Jewelry)** ❑ YES ❑ NO | |

**LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antiacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).**

| Medication | Dosage | Times/Day | Reason for Taking/Doctor who Prescribed |
|---|---|---|---|
| | | | |
| | | | |
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303 East Wood Street • Spartanburg, SC 29303 • Phone: 864-208-8800 • Fax: 864-208-8857
www.orthopedicspecialties.com

# NOTICE OF PRIVACY POLICIES AND PRACTICES

# FOR

# ORTHOPEDIC SPECIALTIES OF SPARTANBURG, LLC

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

**INTRODUCTION:**
At Orthopedic Specialties of Spartanburg, LLC we are committed to treating and using protected health information (PHI) responsibly. This NOTICE describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective September 23, 2013 and applies to all protected health information as defined by federal regulations.

**UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION:**
Each time you visit Orthopedic Specialties a record of your visit is created. Typically, this record contains information about your visit including examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication with other health professionals involved in your care
- Legal document outline and describing the care you received
- A tool that you, or another payer (your insurance company) will use to verify that services billed were actually provided
- An education tool for medical health providers
- A source of medical research
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards
- A source of data for planning and/or marketing
- A tool that we can reference to ensure the highest quality of care and patient satisfaction

Understanding what is in your record and how your health information is used helps you to ensure it's accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

**YOUR 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

**OUR RESPONSIBILITIES:**

Orthopedic Specialties of Spartanburg LLC is required to:
- Maintain the privacy of your health information
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have regarding communications of health information via alternative means and locations

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. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all PHI that we maintain. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to procedures included in the authorization.

**HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION:**

We will use your health information for treatment: Your health information may be used by staff members or disclosed to other healthcare 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.

We will use your information for payment. Your health plan may request and receive information on dates of service, the services provided and the medical condition being treated in order to pay for the service rendered to you.

We will use your information for regular health operations. Your health information may be used as necessary to support the day-to-day activities and management of Orthopedic Specialties. For example: information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Business Associates: In some instances, we have contracted separate entities to provide services for us. These "associates" require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these "business associates" might be a billing service, collection agency, answering services and computer software/hardware provider.

Communication with family: Due to the nature of our field, we will use our best judgment when disclosing health information to a family member, other relatives, or any other person that is involved in your care or that you have authorized to receive this information. Please inform the practice when you do not wish a family member or other individual to have authorization to receive your information.

Research/Teaching/Training: We may use your information for the purpose of research, teaching and training.

Healthcare Oversight: Federal law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Appointment Reminders: The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders will be performed with a phone call where a brief, non-specific message may be left on your answering machine. If you don't approve of this method or if you prefer an alternative method (i.e. Patient Portal) please inform the practice.

Other Uses and Disclosures: 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 that occurred before you notified us of your decision.

**FOR MORE INFORMATION OR TO REPORT A PROBLEM**:

If you have complaints, questions or would like additional information regarding this notice or the privacy practices of Orthopedic Specialties, please contact:

Julia Pye, Privacy Official
Orthopedic Specialties of Spartanburg, LLC
303 E Wood Street
Spartanburg, SC 29303
Telephone number: (864)208-8810

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independency Avenue, S.W.
Room 509F, HHH Building
Washington, DC 20201

Orthopedic Specialties
of Spartanburg

# Acknowledgment Receipt of Notice of Privacy Practices

Orthopedic Specialties of Spartanburg, LLC has provided me its Notice of Privacy Practices for my review.

I understand that the purpose of this notice is to inform me of my rights pertaining to my Protected Health Information (”PHI”) and also the ways in which Orthopedic Specialties of Spartanburg, LLC may use or disclose my PHI.

I authorize the person(s) listed below to receive all health information about appointments, treatment, &/or other information pertinent to my healthcare &/or payment for my healthcare provided.

Name/Relationship:_____Phone:_____

Name/Relationship:_____Phone:_____

Name/Relationship:_____Phone:_____

Name/Relationship:_____Phone:_____

Patient Name _____

Patient Date of Birth _____

Patient Social Security Number _____

_____ _____

Patient Signature Date

Orthopedic Specialties
of Spartanburg

MEDICATION MANAGEMENT AGREEMENT

Controlled narcotic medications are very useful but have a high potential for misuse and are therefore closely controlled by the local, state and federal government. They are intended to relieve pain and to improve function and/or ability to work, not simply to make you feel good. Because my physician is prescribing such medication for me to help manage my pain, I agree to the following conditions:

- I understand that the main treatment goal is to improve my ability to function and/or work and/or reduce pain. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by the following better health habits: exercise, weight control, and avoiding the use of alcohol and tobacco. I must also comply with the treatment plan as prescribed by my doctor. I understand that only by following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

- I understand that the long term advantages and disadvantages of chronic opioid use have yet to be scientifically determined and that the treatment may change throughout my time as a patient of Orthopedic Specialties of Spartanburg, LLC. I understand, accept, and agree that there may be unknown risk associated with the long term use of controlled substances that my physician will advise me as knowledge and training advances and will make appropriate treatment changes.

- I am responsible for my controlled substance medications. If the prescription medication is lost, misplaced or stolen, or if I use it up sooner than prescribed, I understand that it will not be replaced.

- I will not request or accept controlled substance medications from any other physician or individual while I am receiving such medication from my physician at this practice. Besides being illegal to do so, it may endanger my health. The only exception is if the medication is prescribed while I am admitted in a hospital.

- Refill Policy:

    - The daily dose may not vary. The weekly/monthly dose must remain constant.
    - No refills will be made early (before the end of the week or month etc.)
    - No refills will be made on Fridays, weekends, holidays or after office hours.
    - No refills will be made by physicians outside of this office.
    - Lost medications will not be a reason to refill medications early.

- I agree to use _____ Pharmacy, located at

  _____, telephone number _____ for all my pain medication. If I change pharmacies for any reason I agree to notify the doctor at the time I receive a prescription and advise my pharmacy of my prior pharmacy's address and telephone number.

- I agree to keep all scheduled appointments. If I am unable to keep an appointment, I agree to call in advance and discuss the reason I am asking to be excused. This must be done before the scheduled visit time.

- It may be deemed necessary by my doctor for me to have a second opinion at any time while I am receiving controlled substances. I understand that if I do not attend this appointment my medications may not be continued or refilled beyond a tapering dose of completion.

- You have my permission to discuss my medical problem with my spouse or significant other

  _____

- I agree to comply with random testing of urine or blood to document the proper use of my medications as well as to confirm compliance. If any illicit drugs are discovered through such testing my doctor will likely stop all prescribing for controlled substance medications and this may result in dismissal from the practice.

- I understand that driving a motor vehicle may not be allowed at times while using controlled substances and that it is my responsibility to comply with the laws of this state while taking the medication prescribed.

- Any failure to comply with this Medication Management Agreement and any guidelines on prescription labels; any attempt to obtain or obtaining narcotics elsewhere (even from other physicians), any sharing of narcotics with others, any alteration of the prescription by a patient, and/or any failure to comply with a request for a random test of urine or blood as agreed upon above will result in termination of this narcotic use program and of our doctor-patient relationship.

- I agree to waive any applicable privilege or right of privacy or confidentiality with the respect to the prescribing of my pain medication and I authorize the doctor and pharmacy to cooperate fully with city, state or law enforcement agency, including the South Carolina Medical Board, in the investigation of possible misuse, sale or other diversion of my pain medication. I authorize the doctor to provide a copy of this agreement to my pharmacy. I understand that if I am under care pursuant to a Worker's Compensation Claim, any records, including drug testing results, must be shared with Worker's Compensation if requested.

I have been fully informed by my doctor regarding psychological dependence (addiction) of a controlled substance, which I understand is rare. I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the desired effect. I do know that I will become physically dependent on the medication. This will occur if I am on the medication for several weeks and when I stop the medication I must do so slowly under medical supervision or I may have withdrawal symptoms.

I have read this contract; fully understand the consequences of violating this contract and I agree to its terms.

_____ _____

Print Patient Name Date

_____ _____

Patient Signature Witness Signature

Orthopedic Specialties
of Spartanburg

**If you are a female, please place a check only under the female column for what applies. If you are a male, please place a check only under the male column for what applies. Add the column and put the total score in the appropriate place.**

# Opioid Risk Tool

Patient:_____ DOB:_____

| MARK EACH BOX THAT APPLIES | FEMALE | MALE |
|---|---|---|
| **Family History of Substance Abuse** | | |
| Alcohol | ☐ 1 | ☐ 3 |
| Illegal Drugs | ☐ 2 | ☐ 3 |
| Rx Drugs | ☐ 4 | ☐ 4 |
| **Personal History of Substance Abuse** | | |
| Alcohol | ☐ 3 | ☐ 3 |
| Illegal Drugs | ☐ 4 | ☐ 4 |
| Rx Drugs | ☐ 5 | ☐ 5 |
| **Age between 16-45 years** | ☐ 1 | ☐ 1 |
| **History of Preadolescent Sexual Abuse** | ☐ 3 | ☐ 0 |
| **Psychological Disease** | | |
| ADD, OCD, Bipolar, Schizophrenia | ☐ 2 | ☐ 2 |
| Depression | ☐ 1 | ☐ 1 |
| **Scoring Total** | | |

Opioid Abuse Risk Scoring Assessment

Low Risk – 3 or lower

Moderate Risk – 4-7

High Risk – 8 or above

Patient Signature:_____ Date:_____