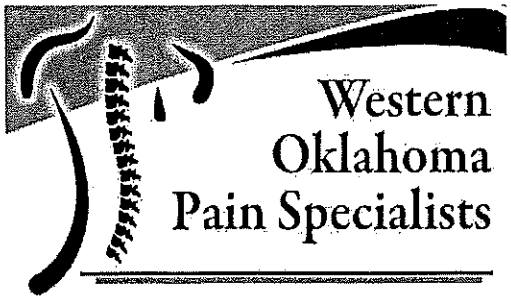

We would like to thank you for choosing Western Oklahoma Pain Specialists.

Attached is your New Patient Paperwork. ***Please complete all 19 pages***. Even if you are only doing injections/procedures, we must have this paperwork in place.

We also need a copy of :

- Driver's license
- Medical insurance (all cards if multiple)

Western Oklahoma Pain Specialists LLC
Brian Blick MD
Patient Demographic Information

Name: Last:_____First_____ Middle_____

Address:_____City:_____State:_____Zip_____

Home phone:_____Cell phone:_____

Primary Care Doctor:_____Referring Doctor:_____

DOB:_____ Sex: Male_____Female_____ Marital Status: _____

SSN_____

Employer Name:_____ Employer Phone #:_____

Email:_____

Preferred Phamacy_____ Pharmacy phone #_____

Race: __American Indian or Alaska Native __Asian __Native Hawaiian or Other Pacific Islander __Black or African American
__ White __Hispanic __Other Race __Other Pacific Islander __unreported/refused to report

Ethnicity: __ Hispanic or Latin __ Not Hispanic or Latin __ Refused to Report

Language: __English __Other, please specify: _____

May we text you in reference to your appointment reminders? Yes or No

May we leave a message regarding your appointment reminders? Yes or No

Guarantor/Responsible Party (if Self, please leave blank)

Must be filled out if patient is a Minor.
Divorced Parents: Parent that brings child in for treatment is responsible for payment of the bill.

Father: _____

Mailing address:_____

City_____ St _____ Zip_____

Contact Phone _____

SSN_____Birthday_____

Employer_____

Work phone #_____

Mother:_____

Mailing address:_____

City_____St_____Zip_____

Contact Phone_____

SSN_____Birthday_____

Employer_____

Work Phone #_____

EMERGENCY Contact: Name_____

Relationship to Patient_____ Phone #_____

Initial here _____

If you have Sooner Care and have primary insurance (other than Sooner Care), you MUST provide us with the primary insurance information. Your Sooner Care will not pay us until your primary insurance has processed the claim. If Sooner Care shows you have other primary insurance inaccurately we will require that you provide us a valid termination date of that insurance and that you contact Sooner Care with that termination date.

Primary Insurance Information: (Present your Insurance Card) * Required Fields

Insurance Company Name:_____

Address:_____City_____State_____Zip_____

Phone:_____Policy Number_____Group # _____

*Insured Name (if not self):_____*DOB:_____

*Relationship to patient:_____

Secondary Insurance Information: (present your Insurance Card) * Required Fields

Insurance Company Name:_____

Address:_____City_____State_____Zip_____

Phone:_____Policy Number_____Group # _____

*Insured Name (if not self):_____*DOB:_____

*Relationship to patient:_____

Primary Care Physician and Phone Number: _____

Referring Provider and Phone Number: _____

Other Treating Physicians, Phone Number and Conditions:

_____

_____

_____

REASON FOR VISIT: _____

Is this Worker's Comp related? _____

If yes, date of injury: _____

Is this an auto accident? (circle answer) YES NO If yes, date of accident: _____

Accident Details if applicable: _____

Are you disabled? (circle answer) YES NO

Permanent Restrictions: _____

_____ % of disability _____

Goals: _____ Return to Work? _____ Become more active? _____ Improve quality of life? _____ Other?

MEDICATIONS: List ALL medications, strength and quantity that you are currently taking:

_____

_____

ALLERGIES: (Please list all allergies and reaction)

_____

_____

HOSPITALIZATIONS: (Please list all prior hospitalizations, including date)

_____

_____

PLEASE CIRCLE ONE

Past Medical History:

abnormal liver functions tests	0 Yes 0 No
AIDS/HIV	0 Yes 0 No
Alcohol abuse	0 Yes 0 No
Anemia	0 Yes 0 No
Angina	0 Yes 0 No
Anxiety	0 Yes 0 No
Arthritis/osteoarthritis	0 Yes 0 No
Arthritis/rheumatoid	0 Yes 0 No
Asthma	0 Yes 0 No
Atrial fibrillation	0 Yes 0 No
Autoimmune disorder	0 Yes 0 No
Bipolar disorder	0 Yes 0 No
Bleeding problems	0 Yes 0 No
Bowel disorder	0 Yes 0 No
Cardiac arrhythmia	0 Yes 0 No
Cirrhosis	0 Yes 0 No
Coronary artery disease	0 Yes 0 No
Crohn's disease	0 Yes 0 No
Depression	0 Yes 0 No
Diabetes, type I	0 Yes 0 No
Diabetes, type II	0 Yes 0 No
Drug abuse	0 Yes 0 No
Emphysema	0 Yes 0 No
Epilepsy	0 Yes 0 No
Gastric ulcer	0 Yes 0 No
Gout	0 Yes 0 No
Heart attack	0 Yes 0 No
Hepatitis B	0 Yes 0 No
Hepatitis C	0 Yes 0 No
Hypertension	0 Yes 0 No
Kidney failure	0 Yes 0 No
Lupus	0 Yes 0 No
Migraine headaches	0 Yes 0 No
Pacemaker	0 Yes 0 No
Schizophrenia	0 Yes 0 No
Seizures	0 Yes 0 No
Sleep apnea	0 Yes 0 No
Stroke	0 Yes 0 No

Surgical History:

appendix removed	0 Yes 0 No
ankle surgery	0 Yes 0 No
bladder surgery	0 Yes 0 No
bowel surgery	0 Yes 0 No
breast biopsy	0 Yes 0 No
carpal tunnel release	0 Yes 0 No
cervical fusion	0 Yes 0 No
coronary artery bypass graft	0 Yes 0 No
gallbladder removed	0 Yes 0 No
gastric bypass	0 Yes 0 No
heart bypass	0 Yes 0 No
hip replacement, left	0 Yes 0 No
hip replacement, right	0 Yes 0 No
hysterectomy	0 Yes 0 No
knee arthroscopy, left	0 Yes 0 No
knee arthroscopy, right	0 Yes 0 No
knee replacement, left	0 Yes 0 No
knee replacement, right	0 Yes 0 No
lumbar fusion	0 Yes 0 No
lumbar laminectomy	0 Yes 0 No
mastectomy	0 Yes 0 No
open reduction, internal fixation (ORIF)	0 Yes 0 No
pacemaker, cardiac	0 Yes 0 No
partial thyroidectomy	0 Yes 0 No
shoulder arthroscopy	0 Yes 0 No
spine surgery	0 Yes 0 No
tonsillectomy	0 Yes 0 No

Family History:

Father Illnesses: _____

Mother Illnesses: _____

Siblings Illnesses: _____

Family Members with an Alcohol or Drug Addictions: _____

ALCOHOL AND TOBACCO Information

Part 1

Did you have a drink containing alcohol in the past year?

NO _____ (if no please move to tobacco section) YES _____ (If yes please answer questions below)

If Yes: How often did you have a drink containing alcohol in the past year?

_____ Monthly or less _____ 2-4 times a month

_____ 2-3 times a week _____ 4 or more times a week

If Yes: How many drinks did you have on a typical day when you were drinking in the past year?

____ 1 or 2 drinks ____ 3 or 4 drinks ____ 5 or 6 drinks ____ 7 to 9 drinks ____ 10 or more drinks

If Yes: How often did you have 6 or more drinks on one occasion in the past year?

_____ Never _____ Less than monthly

_____ Monthly _____ Weekly

_____ Daily or almost daily

Part 2

Nonsmoker _____ (if you have never smoked you have completed this form)

Former smoker _____ (please complete this section below)

Smoker _____ (please complete this section below)

Former Smoker: How long has it been since you last smoked?

_____< 1 month _____1-3 months _____3-6 months _____6-12 months

_____1-5 years _____5-10 years _____> 10 years

Current Smoker: How often do you smoke cigarettes?

_____every day _____some days, but not every day

How many cigarettes a day do you smoke?

_____5 or less _____6-10 _____11-20 _____21-30 _____ 31 or more

How soon after you wake up do you smoke your first cigarette?

_____ within 5 minutes _____ 6-30 minutes _____ 31-60 minutes_____60 minutes

Are you interested in quitting?

_____ Ready to quit _____ Thinking about quitting _____ Not ready to quit

SITE OF PAIN: _____

ON a scale from 0 (no pain) to 10 (excruciating) rate your pain:

At its WORST: _____ At its LEAST: _____ At its USUAL: _____ TODAY: _____

Describe your pain: sharp, dull, burning, shooting,

When did your pain start: _____

What makes your pain worse: _____

What makes your pain better: _____

How many hours in a day are you in enough pain requiring medication (1-24) _____

What time of day is your pain the worst: _____

IS THIS AN INJUST RELATED TO A MOTOR VEHICLE ACCIDENT? YES _____ NO _____

If Yes, date of inquiry: _____ Date pain began: _____ Occupation: _____

List all previous Workers' Comp injuries: _____

Previous Treatment:

Surgeries: _____

Medical: _____

Any Nerve Blocks, Epidural Blocks: YES NO _____

Physical Therapy or other treatment: _____

Check any test performed for evaluation of pain:

_____ Lumbar MRI Location: _____ Date: _____

_____ Cervical MRI Location: _____ Date: _____

_____ CT Scan Location: _____ Date: _____

_____ Myelogram Location: _____ Date: _____

_____ X-Rays Location: _____ Date: _____

_____ Bone Scan Location: _____ Date: _____

_____ EMG Location: _____ Date: _____

_____ Discogram Location: _____ Date: _____

PLEASE CIRCLE ONE

If you have had in the last year :

Review of Systems:

Cardiovascular

Chest pain	0 Yes	0 No
Difficulty lying flat	0 Yes	0 No
Fluid accumulation in the legs	0 Yes	0 No
Irregular heartbeat	0 Yes	0 No
Palpitations	0 Yes	0 No

Gastrointestinal

Blood in stool	0 Yes	0 No
Constipation	0 Yes	0 No
Diarrhea	0 Yes	0 No
Change in bowel habits	0 Yes	0 No

Neurologic

Balance difficulty	0 Yes	0 No
Difficulty speaking	0 Yes	0 No
Dizziness	0 Yes	0 No
Fainting	0 Yes	0 No
Gait abnormality	0 Yes	0 No
Loss of strength	0 Yes	0 No
Paralysis	0 Yes	0 No
Seizures	0 Yes	0 No

Respiratory

Absent pulses in feet	0 Yes	0 No
Absent pulses in hands	0 Yes	0 No
Blanching of skin	0 Yes	0 No
Cold extremities	0 Yes	0 No
Ulceration of feet	0 Yes	0 No

Musculoskeletal

Joint stiffness	0 Yes	0 No
Leg cramps	0 Yes	0 No
Pain in shoulder(s)	0 Yes	0 No
Sciatica	0 Yes	0 No
Swollen joints	0 Yes	0 No
Trauma to ankle(s)	0 Yes	0 No
Trauma to arm(s)	0 Yes	0 No
Trauma to hip(s)	0 Yes	0 No
Trauma to knee(s)	0 Yes	0 No
Weakness	0 Yes	0 No

Psychiatric

anxiety	0 Yes	0 No
depressed mood	0 Yes	0 No
difficult sleeping	0 Yes	0 No
suicidal thoughts	0 Yes	0 No

Women Only

breast lump	0 Yes	0 No
heavy bleeding during menses	0 Yes	0 No
painful intercourse	0 Yes	0 No

Genitourinary

blood in urine	0 Yes	0 No
difficulty urinating	0 Yes	0 No

Men Only

hernia	0 Yes	0 No
hard testicle	0 Yes	0 No
difficulty initiating stream	0 Yes	0 No

Western Oklahoma Pain Specialists
Brian E. Blick, M.D.
1901 W. 3rd Street, Suite C
Elk City, OK 73644

OFFICE POLICIES

1. **Co-pays and Patient Balances are due in full before you see the doctor.** If you are unable to pay your co-pay, we will reschedule your appointment. The only exception will be if you have spoken with the office manage prior to your appointment and made arrangements for payment. We accept cash, personal checks, Visa and MasterCard. If you should have a check returned from your bank for any reason, there will be a $25.00 charge in addition to the amount of the check which must be paid in case or with a money order prior to your next visit. We will file claims with your insurance company for office visits and procedures; however, if your insurance does not pay within 90 days, you will be responsible for the bill. If it becomes necessary to send your account to an outside collection agency, their fees will be added to your balance.
2. If you need to cancel or reschedule your office visit, please call 24 hours in advance. If you fail to cancel and do not keep your appointment, you will be charged $25.00. **This will be due from you at your next visit and cannot be billed to your insurance.**
3. Please limit phone calls to the office to 1 call and 1 message, multiple calls only delay the process. Please allow 24 to 48 hours for a return call.
4. In regard to prescription refills, please contact your pharmacy and they will fax us a request. There are NO prescription refills after hours or on weekends or holidays. NO EXCEPTIONS!
5. If you require a copy of your medical records, you will be required to sign a release form and allow two weeks for copying. There is a $25.00 charge to be paid in full at time of request. We will not fax records to anyone other than another physician who requests them with a signed release form.
6. Your children are welcome in the office, but must remain seated and quiet at all times. If they are disruptive or destructive, you will be asked to reschedule your appointment for a time when you will not have to bring them with you.
7. We only treat patients with Workers' Compensation injuries with prior authorization from the insurance carrier. You must also provide us with the correct billing information before your first appointment. If you do not give us the correct information and your claims are denied, you will be responsible for the entire bill.

Print Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

Western Oklahoma Pain Specialists
Brian E. Blick, M.D.
1901 W. 3rd Street, Suite C
Elk City, OK 73644

PAIN PATIENT'S BILL OF RIGHTS

The following Office Policy of Western Oklahoma Pain Specialists, regarding the Patient's Bill of Rights, particularly with respect to Pain Management. It is an exception that compliance with the Patient's Bill of Rights can contribute to an effective program for the patient.

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain from the credentialed practitioner complete and current information concerning the:
    a. **Diagnosis;**
    b. **Proposed treatment; and**
    c. **Expected prognosis in terms that the patient may reasonably be expected to understand.**
    d. **When it is not advisable to give such information to the patient, the information should be made available to an appropriate person (medical proxy) on the patient's behalf.**
3. The patient has the right to receive the necessary information for the medical decision-making and the granting of informed consent from the treating credential practitioner prior to the start of any procedure or treatment. This information shall include at the minimum: the expected procedure or treatment, what alternatives exist if any, what are the likely risks from the procedure or treatment, what may occur if no treatment is undertaken, and the length of probable duration of incapacitation if any is expected.
4. The patient has the right to refuse any and all treatment to the extent permitted by law, and to be informed of any medical consequences of this action.
5. The patient has the right to every consideration of privacy concerning the medical care provided except when there is an imminent risk to the individual or others, or when the practitioner is ordered by court to breach confidentiality.
6. The patient has the right to be advices if the practitioner, agency, or facility propose to engage in any form of human experimentation affecting the care of the treatment provided. The patient has the right to refuse to participate in research projects or to withdraw continued consent to participate without repercussions.
7. The patient has the right to examine and receive an explanation of the bill for professional services rendered.

All pain management activities are to be provided with an overriding concern for the patient, and above all, the recognition of the patient's dignity as a human being.

_____ _____

Patient Signature **Date**

Western Oklahoma Pain Specialists
Brian E. Blick, M.D.
1901 W. 3rd Street, Suite C
Elk City, OK 73644

HIPAA Signature Page

Acknowledgment of Receipt of "Notice of Privacy Practices"

I acknowledge that **Western Oklahoma Pain Specialists** has given me a copy of the Privacy Notice either by web, email, US Mail, or in person by the federal government's HIPAA legislation. I have been provided the opportunity to discuss concerns I may have regarding the privacy of my health.

Date: _____ Name of Patient: _____

The government mandated that as of April 14, 2003, all health care patients are to receive from their clinicians a notice (hereafter referred to as "Notice") regarding the protection of their private health care information in compliance with the Health Insurance Portability and Accountability Act ("HIPPA") Privacy Rule (45 C.F.R. parts 160 and 164).

This form documents that your physician has given you the "Notice" that is required. HIPAA covers what is called "protected health information" (PHI) that is used for treatment, payment and health care operations. PHI is information in your health record that could identify you.

The Notice contains basic information about:

1. How your PHI may be used and disclosed for treatment, payment and health care operations (these terms are defined in the Notice).
2. Which uses and disclosures require authorization from you and which do not.
3. How you may revoke an authorization you have made.
4. Certain rights you have to restrict use and disclosure of PHI, to receive confidential communications by alternative means and at alternative locations, to inspect and copy your records, to amend your records or to have an accounting of disclosures.
5. A list of my duties to protect the privacy of PHI, my right to change the privacy policies and practice described in the Notice, and how I will inform you of changes.
6. What you can do if you have any complaints about violations of your privacy rights, about decisions regarding access to your records I may make.
7. Any restrictions and limitations you or I wish to put on the use and disclosure of your PHI.

Generally, this Notice is given to a patient in person, by email, or downloaded from the web. A copy of the Notice is available by request.

This page documents that you have received a copy of the Notice.

Patient Signature: _____ Date: _____

Western Oklahoma Pain Specialists
Brian E. Blick, M.D.
1901 W. 3rd Street, Suite C
Elk City, OK 73644

I have been offered or received and read the following documents:

1. Patient Office Policies
2. Patient's Bill of Rights
3. HIPAA (a detailed copy of HIPAA is provided at our office)

I AGREE TO FOLLOW THESE POLICIES:

Print Name: _____

DOB: _____

SIGNATURE: _____ DATE: _____

CONSENT TO ACCESS EXTERNAL PRESCRIPTION HISTORY

PLEASE SIGN ONLY AFTER YOU HAVE READ AND UNDERSTAND THE FOLLWING:

Patient Name (please print)_____ DOB_____

I, _____ whose signature appears below, authorize Western Oklahoma Pain Specialists and its affiliated providers to view the external prescription history via the RxHub services for the patient listed below.

I understand that a prescription history from multiple unaffiliated medical providers, insurance companies, and pharmacy benefits managers may be viewable by the providers and staff of Western Oklahoma Pain Specialists and may include past prescriptions from several years ago.

MY SIGNATURE CERTIFIES THAT I HAVE READ, UNDERSTAND, AND AUTHORIZE THE ACCESS OF EXTERNAL PRESCRIPTION HISTORY.

_____	_____	_____
Signature of Patient or Guardian	**Date**	**If Guardian, Relationship to Patient**

_____	_____
Witness of Signature	**Date**

Western Oklahoma Pain Specialists
Brian E. Blick, M.D.
1901 W. 3rd Street, Suite C
Elk City, OK 73644

Notification of Non-Covered or Not Medically Necessary Services

Urine Drug Screening and Urine Drug Confirmations

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

To increase patient safety in the prescribing of controlled substances, Western Oklahoma Pain Specialists has instituted a urine drug testing policy that includes urine drug screening. The most basic level of screening is conducted frequently and these results are confirmed via advance laboratory confirmations under certain circumstances.

Please recognize that your insurance company may, or may not, cover the costs of urine drug screening. We feel strongly that this is a medically necessary test for responsible and safe prescribing of strong pain relivers. **We will not allow exceptions to our standard policy.**

The performance of these tests incurs significant cost upon the practice and you will be held responsible for the costs should your insurance fail to reimburse for these services as being non-covered or not medically necessary.

_____ _____
Patient Signature Date

*I have read your policy and agree to pay for these services outlined above that might be non-covered or not medically necessary by my insurance contract as indicated by my signature for the above date.

Western Oklahoma Pain Specialists
Dr. Brian E. Blick, MD

1710 W. 3rd St. Suite 100
Elk City, OK 73644
Phone: (580) 339-8001
Fax: (580) 339-8031

2021 Pain Management Agreement

The purpose of this agreement is to prevent misunderstanding about certain medication you will be taking for pain management. This is to help you and your doctors comply with the laws regarding controlled medications. I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement. I understand that failure to comply with this agreement, my doctor will stop prescribing these controlled medications. In, this case, the doctor will taper off the medications over a period of several days, as recommended. I will communicate fully with my doctor about the character and intensity of my pain, the effect of my pain on daily life and how well the medicine is helping to relieve pain.

INITIAL BY EACH LINE

_____ 1. **I WILL NOT** use any illegal controlled substances.

_____ 2. **I WILL NOT** share, sell or trade my medication with anyone.

_____ 3. **I WILL NOT** attempt to obtain any CONTROLLED MEDICATIONS, including opioid pain medicines, controlled stimulants or anxiety medication from another, unless prior approval through WOPS medical staff.

_____ 4. **I WILL** safeguard my medicine from loss or theft. Lost or stolen medicines will **NOT** be replaced.

_____ 5. **I AGREE** that refills of my prescriptions will be made after office visit with my physician.

_____ 6. **I UNDERSTAND** that my medication will be sent electronically to the pharmacy after 5pm of office visit.

_____ 7. **I AGREE** to use only ONE PHARMACY _____ TOWN _____

_____ 8. **I UNDERSTAND** that prescriptions **will only be sent** to listed to pharmacy listed above.

_____ 9. **I AUTHORIZE** my physician and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including Oklahoma board of Pharmacy, In the investigation of any possible misuse, sale or other diversion of my medication. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive all applicable privileges or right of privacy or confidentiality with respect of these authorizations. I authorize my doctor to specifically discuss my medications dispensed by the pharmacy with the pharmacist.

_____ 10. **I AGREE** I will submit hair sample, blood or urine drug screen when requested by my doctor to determine my compliance with the program of medicine.

_____ 11. **I AGREE** that I will use my medications as prescribed by physician.

_____ 12. **I AGREE** I will bring all my prescribed medications to the office every visit.

_____ 13. **I AGREE** to random pill counts at any time and failure to come into the office within 24 hours will result in termination. I agree to come to the office for the sole purpose of a random pill count and understand that is necessary for my doctor to attempt to ensure medication utilization compliance.

_____ 14. **I UNDERSTAND** that more than 2 Failed Urine drug screen result in termination of medications prescribed by Western Oklahoma Pain Specialists.

_____ 15. **I UNDERSTAND/AGREE** all medications will be sent by to Pharmacy electronically and prior authorization may be needed. I will give the office 24 hours after appointment before calling about medications.

_____ 16. I **UNDERSTAND** Multiple phone calls to the office about medications may result in termination.

_____ 17. I **WILL** be respectful to ANY WOPS Staff and physicians. Cursing, yelling and being disrespectful to staff will result in immediate termination.

_____ 18. **I AGREE** and fully understand all parts of this pain management agreement. I agree that if I have any questions or concerns regarding this agreement, that they have been fully answered to my satisfaction.

_____ 19. I **AGREE** to have a primary care provider for all my NON-PAIN medical needs. I will need to establish care with a Primary Care physician within 60 days of this contract.

_____ 20. **I UNDERSTAND THAT FAILURE TO COMPLY WITH ANY OF THESE CONDITIONS WILL RESULT IN TERMINATION OF PRESCRITIONS PRESCRIBED BY WESTERN OKLAHOMA PAIN SPECIALISTS PHYSICIANS AND IN TERMINATION FROM WESTERN OKLAHOMA PAIN SPECIALISTS CARE.**

This agreement is entered into this _____ day of _____, 2021.

_____ _____

Patient Print Name **Patient Signature**

_____ WOPS WITNESS – COPY PLACED IN CHART

Western Oklahoma Pain Specialists
Dr. Brian E. Blick, MD
1901 W. 3rd St., Ste C
Elk City, OK 73644
580-339-8001 F: 580-339-8031

Authorization for Release of Information to Family Members

Patient Name _____ Date of Birth _____

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Western Oklahoma Pain Specialists to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature: _____ Date: _____

Western Oklahoma Pain Specialists
Dr. Brian E. Blick, MD
1901 W. 3rd St., Ste C
Elk City, OK 73644
580-339-8001 Fax: 580-339-8031

Effective May 1st, 2018, Western Oklahoma Pain Specialists will no longer prescribe narcotic pain medication to those who concurrently use benzodiazepines or benzodiazepine-like medications. The US Food and Drug Administration (FDA) announced clinicians should not prescribe opioid pain medicines together with benzodiazepines (or the like) to **reduce the risk of overdose deaths.** Both classes of drugs are central nervous system (CNS) depressants, which can trigger shallow and/or slowed breathing, coma, and death, especially when combined. The FDA has spelled out these precautions in class-wide boxed warnings on labels of opioid painkillers, benzodiazepines, and other CNS depressants. The death toll has increased by 41% in the number of patients who were prescribed both an opioid painkiller and a benzodiazepine between 2002 and 2014, according to the FDA. Insurance companies and pharmacies have also made changes to their policies to reduce this risk by denying, covering or filling your medications if you're on opioid medication and benzodiazepines concurrently.

If you are currently being prescribed a benzodiazepine or benzodiazepine-like medications (see list below) you will have until your next follow-up and/or 2 months to discuss this change with your prescribing physician and taper accordingly. If you are unable to discontinue such medication, your pain medication will be tapered and/or discontinued at that time. **This is non-negotiable**. If you have any additional questions regarding the above statement, please discuss this with your provider at your appointment.

Benzodiazepines/Benzodiazepines-Like Medications to Avoid

- Xanax (alprazolam)
- Klonopin (clonazepam)
- Restoril (temazepam)
- Ativan (Lorazepam)
- Oxazepam

- Lunesta (eszopiclone)
- Ambien (zolpidem)
- Valium (diazepam)
- Halcion (triazolam)
- Clorazepate

This list is not all-inclusive, if you have any concern regarding your medication, please discuss with the provider.

Brian E. Blick, M.D.
Jayne Bentley, APRN-CNP

My signature below acknowledges that I have read and understand this policy.

Patient's Signature: _____ Date: _____

Print Name: _____

Consent for Chronic Opioid Therapy

I understand that Dr. Brian E. Blick ("my physician") is recommending opioid medicine, sometimes called narcotic analgesics, to treat my _____.

I understand that this medication is being recommended because my pain complaints are moderate to severe and other treatments have no sufficiently helped my pain. I understand that many medications can have interactions with opioids that can either increase or decrease their effect. Therefore, I have told my physician about all other medicines and treatments that I am receiving – and that I will promptly advice my physician if I start to take any new medications or have new treatments. Likewise, I have told my physician about my complete personal drug history and that of my family.

I have been informed by my physician that the initiation of a narcotic/opioid medication is a trial. Continuation of the medication is based on evidence of benefit to me from, associated side effects of, and compliance with instructions on, usage of the medication. I have also been informed by my physician that continuation and any changes in dosage of the medication will be determined by pain relief, functional improvement, side effects, and adherence to usage restrictions. Lack of significant improvement, the development of adverse side effects, or other considerations may lead my physician to discontinue this treatment or to change dosage.

It has been explained to me that taking narcotic/opioid medication has certain risks associated with it. These include, but are not limited to, the following:

- Allergic reactions
- Overdose (which could result in harm or even death)
- Slowing of breathing rate
- Slowing of reflexes or reaction time
- Sleepiness, drowsiness, dizziness, and/or confusion
- Impaired judgment and inability to operate machines or drive motor vehicles
- Nausea, vomiting, and/or constipation
- Itching
- Physical dependence or tolerance to the pain-relieving properties of the medication. (This means that if my medication is stopped, reduced in dose, or rendered less effective by other medications I may be taking, I may experience runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. These can be very painful but are generally not life-threatening.)
- Addiction
- Failure to provide pain relief
- Changes in sexual function (This is generally caused by reduced testosterone levels. Such reduced levels may affect mood, stamina, sexual desire and physical and sexual performance.)
- Changes in hormonal levels

In addition, use of these medications poses special risks to women who are pregnant or may become pregnant. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetrician and this office to inform them. I have been advised that, should I carry a baby to delivery while taking this medication, the baby will be physically dependent upon opioids. I also understand that birth defects can occur whether or not the mother is on medicines and there is always the possibility that my

child will have a birth defect while I am taking an opioid. Furthermore, I recognize that the long-term consequence on a child's development who was exposed to opioids is not understood.

It has been explained to me that there are other treatments that do not involve use of narcotic/opioid medications. Having been informed to these risks and potential benefits both of such medications and possible alternative treatments, I have freely consented to taking the narcotic/opioid medication.

I would not that I have been give the opportunity to ask any questions that I may have – and that any questions that I have raised have been discussed to my satisfaction.

I will take this/these medication(s) only as prescribed and I will not change the amount or dosing frequency without authorization from my physician. I understand that unauthorized changes may result in my running out of medications early, and early refills will not be allowed. I also understand that if I do not take the medication correctly, I may have withdrawal reactions that may include stomach pain, sweating, anxiety, nausea, vomiting and general discomfort.

I will obtain all opioid prescriptions from my physician or, during his or her absence, by the covering physician. Requests for pain medications from the on-call physician (nights and weekends) will not be honored. I will not request medications outside of normal business hours.

I hereby authorize my physician to discuss all diagnostic and treatment details of my condition with the pharmacists at the dispensing pharmacy.

I will submit to random pill counts and urine drug tests as requested by my physician to monitor my treatment. I understand that the presence of any unauthorized substances in my urine may prompt a referral for assessment of addiction or chemical dependency and could result in discontinuation of further opioid prescriptions. I also understand that failure to follow these rules may lead to a delay in medication or may no longer being treated by my physician after a 30-day period.

I will not share, sell or otherwise permit others to have access to these medications.

I HAVE READ THIS FORM OR HAVE HAD IT READ TO ME. I UNDERSTAND ALL OF IT. I HAVE HAD A CHACE TO HAVE ALL OF MY QUESTIONS REGARDING THIS TREATMENT ANSWERED TO MY SATISFACTION. BY SIGNING THIS FORM VOLUNTARILY, I GIVE MY CONSENT FOR THE TREATMENT OF MY PAIN WITH OPIOID PAIN MEDICINES.
I UNDERSTAND AND AGREE THAT FAILURE TO ADHERE TO THESE POLICIES WILL BE CONSIDERED NONCOMPLIANCE AND MAY RESULT IN CESSATION OF OPIOID PRESCRIBING BY MY PHYSICIAN AND POSSIBLE DISMISSAL FROM THIS CLINIC.

Patient Name _____

Patient signature _____

Date _____

Pain Disability Questionnaire

The Pain Disability Questionnaire is used in Chapter 3 Pain (6th ed, 43-44) and Chapter 17 Spine (6th ed, 599-600). The format provided utilizes a centimeter scale to score, however the size in the *Guides* does not correspond with the same scale. An alternative approach (illustrated below) provides easily administered and scored numerical scales.

Patient Name _____ Date _____

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally — Unable to work at all
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

2. Does your pain interfere with personal care (such as washing, dressing, etc)?
Take care of myself completely — Need help with all my personal care
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

3. Does your pain interfere with your traveling?
Travel anywhere I like — Only travel to see doctors
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

4. Does your pain affect your ability to sit or stand?
No problems — Cannot sit /stand at all
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems — Cannot do at all
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems — Cannot do at all
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

7. Does your pain affect your ability to walk or run?
No problems — Cannot walk/run at all
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

8. Has your income declined since your pain began?
No decline — Lost all income
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

9. Do you have to take pain medication every day to control your pain?
No medication needed — On pain medication throughout the day
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

10. Does your pain force your to see doctors much more often than before your pain began?
Never see doctors — See doctors weekly
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem — Never see them
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — Total interference
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help — Need help all the time
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — Severe depression / tension
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems — Severe problems
0 ——— 1 ——— 2 ——— 3 ——— 4 ——— 5 ——— 6 ——— 7 ——— 8 ——— 9 ——— 10

Anagnostis C, Gatchel RJ, Mayer TG. The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302.

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	o	o	o	o	o
2. How often have you felt a need for higher doses of medication to treat your pain?	o	o	o	o	o
3. How often have you felt impatient with your doctors?	o	o	o	o	o
4. How often have you felt that things are just too overwhelming that you can't handle them?	o	o	o	o	o
5. How often is there tension in the home?	o	o	o	o	o
6. How often have you counted pain pills to see how many are remaining?	o	o	o	o	o
7. How often have you been concerned that people will judge you for taking pain medication?	o	o	o	o	o
8. How often do you feel bored?	o	o	o	o	o
9. How often have you taken more pain medication than you were supposed to?	o	o	o	o	o
10. How often have you worried about being left alone?	o	o	o	o	o
11. How often have you felt a craving for medication?	o	o	o	o	o
12. How often have others expressed concern over your use of medication?	o	o	o	o	o

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers. Thank you.