THE ORTHOPAEDIC CENTER
PATIENT INFORMATION

DEMOGRAPHICS ***CHART #*** _____

FIRST NAME: _____MIDDLE INITIAL: _____ LAST NAME: _____

DOB: _____

ADDRESS: _____

_____

_____

HOME PHONE: _____
WORK PHONE: _____
CELL PHONE: _____ PREFERRED PHARMACY / PHONE: _____
EMAIL: _____

Preferred Method of Communication: ☐ Home Ph. ☐ Work Ph. ☐ Cell Ph. ☐ Email

GENDER: ☐M ☐F SSN_____-_____-_____ Preferred Language: _____

Ethnicity:
☐ White, non Hispanic
☐ Black, non Hispanic
☐ Asian / Pacific Islander
☐ American Indian or Alaskan
☐ Other _____
☐ Prefer not to give

Martial Status:
☐Married
☐Single
☐Divorced
☐Widowed

Referring Physician: _____

EMPLOYMENT / EMPLOYER: _____

EMERGENCY CONTACT

FIRST NAME: _____ LAST NAME: _____

PHONE # _____ DOB: _____

RELATION TO PATIENT: _____ HIPPA CONSENT: ☐ YES ☐ NO

(ADDITIONAL CONTACTS ON BACK)

INSURANCE

INSURANCE: _____
POLICY # _____GROUP # _____
INS'D NAME: _____SSN _____DOB_____
EMPLOYER:_____
(MUST BE LISTED AS EMERGENCY CONTACT)

INSURANCE: _____
POLICY # _____GROUP # _____
INS'D NAME: _____SSN _____DOB_____
EMPLOYER._____
(MUST BE LISTED AS EMERGENCY CONTACT)

GUARANTOR

FIRST NAME: _____ MIDDLE INITIAL _____ LAST NAME _____
RELATION TO PATIENT: _____SSN _____DOB: _____
ADDRESS: _____
_____ HOME # _____
_____ WORK # _____
EMPLOYER _____ CELL # _____

PATIENT SIGNATURE_____ **DATE** _____

EMERGENCY CONTACT

FIRST NAME: _____LAST NAME: _____
PHONE # _____ DOB: _____
RELATION TO PATIENT: _____ HIPPA CONSENT: ☐ YES ☐ NO

EMERGENCY CONTACT

FIRST NAME: _____LAST NAME: _____
PHONE # _____ DOB: _____
RELATION TO PATIENT: _____ HIPPA CONSENT: ☐ YES ☐ NO

EMERGENCY CONTACT

FIRST NAME: _____LAST NAME: _____
PHONE # _____ DOB: _____
RELATION TO PATIENT: _____ HIPPA CONSENT: ☐ YES ☐ NO

Bell III Building
1809 East 13th Street, Ste 100
Tulsa, OK 74104-4243
918-582-6800
918-582-6060 fax
www.toctulsa.com

FINANCIAL POLICY

Payment is due at the time services are rendered 72 hours prior to scheduled procedures; this includes self-pay, insurance co-pays and/or deductibles. A current insurance card must be presented at each office visit. As a service to our patients, we will file your medical claims for the date-of-service with insurance information we have available at that time. It is your responsibility to inform us of any changes in your insurance or personal information, such as address and/or phone changes.

Accounts with balances are considered past due at 31 days without a payment. Once an account is delinquent, it may be considered for collection procedures and placed with an independent agency. Should your account be turned for collection procedures, all future services will be suspended until financial matters are resolved.

We realize information surrounding health care and insurance can be difficult and confusing at times, that is why we are here to assist in this process as you seek to improve your health. If you have any questions or should you feel that you cannot meet the terms set forth with the Financial Policy, please feel free to contact us at 918/582-6800. Again, thank you for choosing The Orthopaedic Center. We look forward to serving you.

PLANS

I hereby assign and convey directly to The Orthopaedic Center, P.C, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by The Orthopaedic Center, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize The Orthopaedic Center to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to The Orthopaedic Center all Plan documents, summary benefit descriptions, insurance policies, and/or settlement information upon written request from The Orthopaedic Center or its attorneys in order to claim such medical benefits.

Patient: _____ DOB: _____ Initials: _____

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to The Orthopaedic Center, P.C. any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from The Orthopaedic Center (including any right to pursue those legal or administrative claims or chose an actions). This constitutes an express and knowing assignment of ERISA breach of fiduciary claims and other legal and/or administrative claims.
I intent by this assignment and designation of authorized representative to convey to The Orthopaedic Center all my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by The Orthopaedic Center, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The Orthopaedic Center, PC is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The Orthopaedic Center, PC as my assignee and my designated authorized representative, may sue any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense. Unless revoked, this assignment is valid for all administrative and judicial reviews under Patient Protection Act/Affordable Care Act (health care reform legislation), ERISA, Medicare and applicable federal and state laws and local.

Fracture Care Policy

If one of our orthopaedic providers diagnoses you, your child, or someone you brought to the clinic with a fracture, the treatment of a fracture includes the clinical exam, x-rays, reading of x-rays, casting/splinting, and following this injury until it has healed.

The charges associated with the care of a fracture (closed treatment of a fracture) are listed as a single charge. The code number and charges associated with this were developed by Medicare guidelines and your insurance company, not by our office. Your explanation of benefits from your insurance company may describe it as a "surgery", but it is not a surgery, but a closed (non-surgical) treatment of the fracture.

The charge for this fracture is a single charge that includes 90 days for follow up care, also known as the global period. You will not be charged for an office visit every time you visit the provider during this 90 days since this is included in your initial fracture care exam and fees. However, there are additional charges for x-rays, casting and materials, and/or braces/splints that are not covered with the fracture fee.

Assignment of Benefits

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including private insurance to THE ORTHOPAEDIC CENTER. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.
Again, thank you for choosing The Orthopaedic Center. We look forward to serving you.

"I have read, understand and agree to the provisions of this Financial and Fracture Care Policy."

Signature: _____ Date: _____

Patient: _____ DOB: _____

1809 E. 13th St., Suite 100, Tulsa, OK 74104
Phone: (918) 582-6800
Fax: (918) 582-6060
www.toctulsa.com

AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Name	Date of Birth	Account #
Address	City	
Area Code & Telephone Number	State	Zip

II. SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me. I hereby authorize **The Orthopaedic Center** to share my protected health information as set forth below, for reasons in addition to those already permitted by law.

A. Person/Organization Receiving Information and Purpose for Sharing

Person/Organization Authorized to Receive My Information (Name, Address, Phone & Fax) | Relationship | Purpose For Sharing Information

_____

B. Information to be shared:

☐ Psychotherapy Notes (if checking this box, no other boxes may be checked)
☐ Entire Medical Record ☐ Mental Health Records ☐ Substance Abuse Records
☐ MRI/X-ray
☐ Billing Information for _____
☐ Medical information compiled between _____ and _____
☐ Other: _____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to The Orthopaedic Center and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that signing this authorization will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to The Orthopaedic Center.
- I understand that I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event: _____

Signature of Patient or Legal Representative	Date
Description of Legal Representative's Authority	Expiration Date (if longer than one year from date of signature or no event is indicated)

Do not write below this line; for completion by The Orthopaedic Center only.

Accepted by: _____ Date: _____

Information was provided to the individual on the following date: _____

Bell III Building
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Tulsa, OK 74104-4243
918-582-6800
918-582-6060 fax
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PATIENT AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

AUTHORIZATION FOR TREATMENT. By virtue of my signature, I authorize The Orthopaedic Center, and any of its employees or other authorized personnel or agents, to provide general health care services for me.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION. I hereby authorize The Orthopaedic Center, and any of its employees or other authorized personnel or agents to release any of my medical records or other personal or medical information to any employee, authorized personnel or other agent of any laboratory or diagnostic testing facility, or other healthcare provider involved in my care or treatment for the purpose of developing an appropriate treatment plan or diagnosis, or for purposes of quality assurance, utilization review or other analyses designed to monitor and maintain a quality of care. In authorizing this release of information, I understand that such information may indicate that I have or may have a communicable and/or non-communicable or venereal disease, including but not limited to diseases such as hepatitis, syphilis, gonorrhea, or HIV or AIDS.

CONSENT FOR E-PRESCRIBING & MEDICATION HISTORY. I understand that as a part of my electronic health record, The Orthopaedic Center will transmit my prescriptions electronically as permitted, to the pharmacy that I designate as my primary pharmacy provider. Additionally, The Orthopaedic Center will obtain the history of all my past prescriptions dating back two years from pharmacy benefit managers and I understand that those prescriptions will become a part of my electronic health record. By signing below, I hereby give consent to the above actions.

PATIENT ACKNOWLEDGMENT. By virtue of my signature below, I hereby acknowledge that I have read and understand all the above, and that I have been given adequate opportunity to ask any questions about the same. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure.

SIGNATURE. By Patient's signature below, Patient represents that Patient is 18 years of age or over and is legally capacitated to give consent to treatment and to authorize release of the above information. By signature of a Parent of Legal Guardian below, such individual represents that Patient is under age 18 (a minor) or has a court appointed guardian.

CONSENT FOR THIRD PARY AUTOMATED MESSAGING. By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a 3rd party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for notifying me of a pending appointment, a missed appointment, or any other healthcare related function. I also authorize my healthcare provider to disclose to 3rd parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to allowing messages being left on my voicemail, answering system, or with another individual, if I am unavailable at the number provided by me.

_____	_____
Patient Signature	Today's Date

_____	_____	_____	
Patient Name Printed	Patient DOB	Patient SSN	

_____	_____	_____	
Signature of Parent/Legal Guardian	Relation to Patient	Date	Time (AM/PM)

1809 E. 13th St., Suite 100, Tulsa, OK 74104
Phone: (918) 582-6800
Fax: (918) 582-6060
Privacy Officer: Bruce Schultz
www.toctulsa.com

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Reporting suspected abuse, neglect, or domestic violence
- Helping with product recalls
- Preventing or reducing a serious threat to anyone's health or safety
- Reporting adverse reactions to medications

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Privacy Contact

The Orthopaedic Center has designated a Privacy Officer, Bruce Schultz, as its contact person for all issues, questions, or concerns regarding our health information privacy practices and your rights under HIPAA. You may contact Mr. Schultz at the following address: The Orthopaedic Center, ATTN: Bruce Schultz, Privacy Officer, 1809 E. 13th St., Suite 100, Tulsa, Oklahoma, 74104; by phone at (918) 582-6800; or by email at: bschultz@toctulsa.com.

THIS NOTICE IS EFFECTIVE JANUARY 1, 2016

1809 E. 13th St., Suite 100, Tulsa, OK 74104
Phone: (918) 582-6800
Fax: (918) 582-6060
Privacy Officer: Bruce Schultz
www.toctulsa.com

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I have received your *Notice of Privacy Practices* containing a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a revised copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (please print): _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason:

The ORTHOPAEDIC CENTER

Height: _____
Weight: _____

Patient Name: _____ **DOB**_____ **Todays Date**_____

Referral: **Y** ☐ **N** ☐ **Name of Referring Physician:**_____

Reason for appointment:_____

Please Describe:_____

_____

Have you been treated by another Physician for this condition? Y ☐ **N** ☐ **Name:**_____

Date of injury or date problem began ____/____/____ **Work Comp Claim: Y** ☐ **N** ☐

Symptoms: (Check ALL that apply)

☐ Discomfort	☐ Numbness	☐ Giving out	☐ Popping
☐ Stiffness	☐ Tingling	☐ Paralysis	☐ Grinding
☐ Soreness	☐ Tenderness	☐ Instability	☐ Swelling

Rate your current Pain: **(No Pain)** **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10** ☐ **(Most Severe Pain)**

Previous Treatment: (Check all that apply)

☐ X-Ray ☐ MRI ☐ Therapy ☐ Injection (Type: _____) ☐ Other _____

Drug Allergies: ☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Sulfa ☐ IV Dye ☐ **No Known Drug Allergies**

Other Drug Allergies: (Please list) _____

Medications: (Please list below) ☐ **No Current Medications**

Medication Name	Medication Name	Medication Name

Claustrophobic Y ☐ ***N*** ☐ ***Pacemaker Y*** ☐ ***N*** ☐ ***Heart Stent Y*** ☐ ***N*** ☐ ***Bone Stimulator Y*** ☐ ***N*** ☐

Medical History:

☐ Migraines	☐ Hypertension	☐ Arthritis	☐ Anemia
☐ COPD	☐ High Cholesterol	☐ GERD	☐ Blood disorder
☐ Asthma	☐ Stroke	☐ Hepatitis	☐ Cancer
☐ Sleep Apnea	☐ Seizures	☐ Liver disease	☐ Blood clots
☐ AIDS or HIV	☐ Depression	☐ Diabetes	☐ Kidney Disease
☐ Heart Disease	☐ Anxiety	☐ Thyroid disorder	☐ Psychiatric disorder

Other Medical History not listed: _____

_____

Past Surgical History: ☐ **No Past Surgical History**

_____

_____

_____

Have you ever had any problems with anesthesia? _____

Do you use tobacco: Y☐ N☐ **Packs per day** _____ **Years** _____ **Do you use illicit Drugs:** Y☐ N☐

Do you drink: Alcohol Y☐N☐ **How Much?** _____ **6 or more cups of caffeine per day:** Y☐ N☐

Occupation_____

Dominant Hand: Right Hand ☐ **Left Hand** ☐

Do you exercise? Y☐N☐

Preferred Pharmacy: _____ **Pharmacy Location:**_____

Have you had the following: Flu Vaccine: Y☐ N☐ **Pneumonia Vaccine:** Y☐ N☐

Family History*:* Please check any that apply.

Diagnosis	Father	Mother	Brother	Sister	Family
Hypertension					
Heart Disease					
Hyperlipidemia					
Stroke (CVA)					
Asthma					
Lung Disease					
Dementia					
Seizures					
Depression					
Kidney Disease					
Arthritis					
Blood Disorder					
Bleeding Disorder					
Diabetes Mellitus					
Tuberculosis					
Bone Cancer					
Breast Cancer					
Lung Cancer					
Prostate Cancer					
Renal Cancer					
Cancer NOS					
Others					

☐ **Adopted** ☐ **No History:**

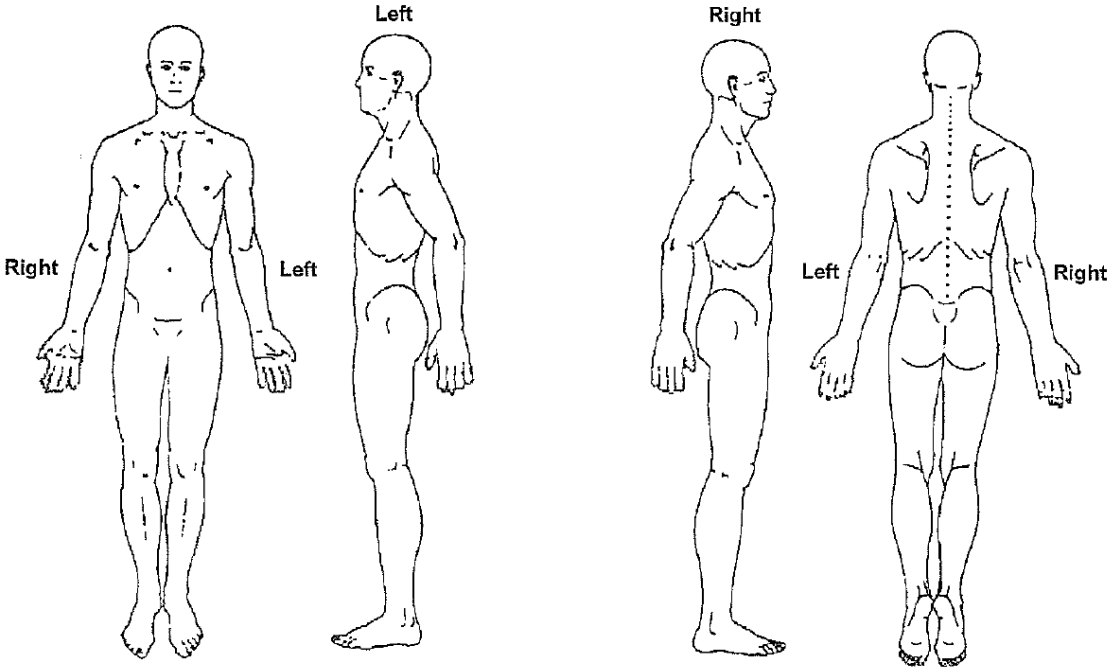
PAIN DIAGRAM FORM

Date: Patient Name: DOB: Chart:

Pain Location: Please use the diagrams to show us where you experience pain, numbness and aching.

Pain = XXXXXX Numbness = 000000 Aching = /////

Please circle all that apply: Burning Throbbing Spasm Weak Pins / Needles Numb Sharp Tender Stabbing Dull Stinging Shooting Cramps Aching Tingling



Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Patient Signature: _____ Date: _____

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THE ORTHOPAEDIC CENTER HAS PARTNERED WITH INTEGRATED LABS ON MEDICATION MONITORING, BELOW IS OUR PROTOCOL

Q: What is the purpose of medication monitoring, and what should I expect?

A: Adherence monitoring is necessary to safeguard our medical practice and ensure the safety of patients on medication therapy.

- Our policy may involve a Urine Drug Screen.
- With patient consent, we will obtain a Urine Drug Screen before beginning medication therapy and randomly at follow-up visits to confirm the appropriate use of the medications.
- The physician/mid-level shall respond to any abnormal result of any monitoring and such response will be recorded in the patient's record.
- When a physician is treating a patient with narcotics for pain or chronic pain the physician will obtain or make a diligent effort to obtain any prior diagnostic records relative to the condition for which the narcotics are being prescribed and will obtain or make a diligent effort to obtain any prior pain treatment records.

Q: When should medication monitoring take place?

A: Medication Monitoring will be considered when:

- Initially to identify all other medications that may be present in a new patient requiring medication therapy to reduce chances of counter effect of medications
- As part of a Preoperative workup to include Nicotine/Nicotine metabolites in patients undergoing spinal fusion or fracture fixation if tobacco use is suspected or known
- Any new prescription for a narcotic pain medication
- Any patient who comes to the practice using narcotic pain medications and requests refills
- Any patient with documented or self-confessed history of illegal substance abuse in remission
- Suspicion of abuse of medications or narcotic pain medication
- Any current patient we have prescribed a narcotic pain medication and/or post operatively
- Any time a patient returns for their first medication refill prescription to protect against diversion of the initial medications prescribed

FOR ANY INTEGRATED LAB BILLING QUESTIONS PLEASE CALL (855) 272-0220