Concord Family Practice

Consent of Disclosure

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

Patient Health Information (PHI)
Under federal law, your patient health information (PHI) is protected and confidential. Patient health information (PHI) includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your patient health information (PHI) also includes payment, billing and insurance information. We are committed to protect the privacy of your PHI.

How we use your patient health information (PHI)
This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations, for administrative purposes, for evaluation of the quality of care, and so forth. We may also share your PHI for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. Under some circumstances we may be required to use or disclose your PHI without your consent.

Treatment: We will use and disclose your PHI to provide you with medical treatment or services. We may also disclose your PHI to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, and so forth.

Payment: We will use and disclose your PHI for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. PHI may be shared with the following: billing companies, insurance companies (health plans), government agencies in order to assist with qualifications of benefits, or collection agencies.

Operation: We may ask you to complete a sign-in sheet or staff members may ask you the reason for your visit so we can better care for you. Despite safeguards, it is always possible in a doctor's office that you may learn information regarding other patients or they may inadvertently learn something about you. In all cases, we expect and request that our patients maintain strict confidentiality of PHI.

We may use and disclose your PHI to perform various routine functions (e.g. quality evaluations or records analysis, training students, other health care providers or ancillary staff such as billing personnel, to assist in resolving problems or complaints within the practice). We may use your PHI to contact you to provide information about referrals, for follow-up with lab results, to inquire about your health or for other reasons. We may share your PHI with Business Associates who assist us in performing routine operational functions, but we will always obtain assurances from them to protect your PHI the same as we do.

Special Situations that DO NOT require your permission: We may be required by law to report gunshot wounds, suspected abuse or neglect, and so on; we may be required to disclose vital statistics, diseases, and similar information to public health authorities; we may be required to disclose information for audits and similar activities, in response to a subpoena or court order, or as required by law enforcement officials. We may release information about you for worker's compensation or similar programs to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in the case of death. Your PHI may also be shared if you are an inmate or under custody of the law which is necessary for your health or the health and safety of other individuals.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services.

In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke the authorization.

Individual Rights
You have certain rights with regard to your PHI, for example:

Unless you object, we may share your PHI with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

You may request restrictions on certain uses and disclosures of your PHI. We are not required to accept all restrictions. If you pay in full for a treatment or service immediately, you can request that we not share this information with your medical insurance provider or our Business Associates. We will make every attempt to accommodate this request and, if we cannot, we will tell you prior to the treatment.

You may ask us to communicate with you confidentially by, for example, sending notices to a special address.

In most cases, you have the right to get a copy of your PHI. There will be a charge for the copies.

If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information by submitting a written request. You may request a list of instances where we have disclosed PHI about you for reasons other than treatment, payment, or operations. The first request in a 12 month period is free. There will be charges for additional reports.

You have the right to obtain a paper copy of this Notice from us, upon request. We will provide you a copy of this Notice on the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible. You have the right to receive notification of any breach of your protected health information.

Our Legal Duty
We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the admissions area and on our website at www.DoctorsCare.com. You can also request a copy of our Notice at any time.

If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may contact the Privacy Officer listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Patient Acknowledgement

Patient's Name (please print) _____ Date of Birth _____ Signature _____ Today's Date _____

Concord Family Practice
Controlled Substance Agreement

If Dr. ***Chen*** ever prescribes such medication for me to help manage my pain, and or anxiety, when I sign this form I acknowledge that I understand and agree to the following conditions to make my treatment as safe and successful as possible **(please initial each numbered item)**:

_____ 1. I am aware that the use of such medicine has certain risks associated with it, including but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia (pain reduction), addiction, and the possibility that the medicines will not provide complete pain relief.

_____ 2. I understand that the main treatment goal is to improve my ability to function by reducing pain or anxiety. 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 following better health habits: exercising, controlling my weight, and avoiding the use of alcohol and tobacco. I understand that only by following a healthier lifestyle can I hope to have the most successful outcome to my pain management treatment.

_____ 3. I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be fully determined and that treatment may change while I am under Dr. Chen's care. I understand, accept, and agree that unknown risks may be associated with the long-term use of controlled substances and that my physician will advise me as knowledge and training advances are made, and will make appropriate treatment changes. I also know there may be other non-opioid options for my pain control.

_____ 4. I agree to tell my doctor about all other medicines and treatments that I am receiving. **I will not request or accept controlled substances/medications from any other physician or individual** while I am receiving such medications from Dr. Chen to do so may endanger my health and/or our physician/patient relationship. The only exception is medication prescribed while I am admitted to a hospital.

_____ 5. I understand the following refill policy:

   a. ***The daily dose may not vary. The weekly/monthly dose must remain constant.***
   b. ***Medications will not be refilled early, even if they have been lost.***
   c. ***Medications will not be refilled on weekends or holidays.***
   d. ***Medications will not be refilled by other physicians.***

_____ 6. I agree to use_____ pharmacy, located at_____for all my pain medications. If I change pharmacies for any reason, I agree to notify the doctor at the time I receive a prescription and advise my new pharmacy of my prior pharmacy's address and telephone number.

_____ 7. I agree to **keep all scheduled appointments**.

_____ 8. At each visit, Dr. Chen will evaluate me for pain relief, side effects, function, and abnormal behavior (anything indicating addiction). I understand that evaluation may also include recommended lab work to monitor my medication's efficacy. **I must keep Dr. Chen fully informed of any changes, Emergency Room visits, lost or stolen medications or any other circumstances affecting my health and well-being.**

_____ 9. Dr. Chen may refer me to another physician for a second opinion while I am receiving controlled substances. I understand that if I do not obtain this second opinion, Dr. Chen may discontinue my medications or refill them with a tapering dose to therapeutically and safely discontinue my use of them.

_____ 10. You have my permission to discuss my ***(medical condition/medication management)*** with my spouse or significant other. ☐ Yes ☐ No If yes provide name _____.

_____ 11. I understand that driving a motor vehicle may be hazardous while taking controlled substances and that it is my responsibility to comply with the laws of this state and conduct myself safely while taking the medication prescribed.

_____ 12. I will not be involved in activities that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include but are not limited to: using heavy equipment or operating a motor vehicle, working at unprotected heights, or being responsible for another individual who is unable to care for himself or herself.

_____ 13. I have been fully informed by Dr. Chen regarding the potential psychological dependence on a controlled substance. 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 know that I may become physically dependent on the medication. This will occur if I am on the medication for several weeks; when I stop the medication I must do so slowly and under medical supervision or I may have withdrawal symptoms.

_____ 14. I will not adjust the medications by myself. I will discuss with Dr. Chen any change in dosage I feel I need. Some patients may develop tolerance, which is the need to increase the dose of the medication to achieve the same effect in terms of pain relief. As a result of other treatment modalities or the natural course of my disease process, my pain may decrease. My medication doses will have to be adjusted by Dr. Chen.

_____ 15. I will take my personal medications as directed, no more and no less. I will not tamper with prescribed medications by cutting, crushing or by any other means altering the intended dose of medication. I will not take the medications by any other than the directed route of administration (oral, trans-dermal, or rectal).

_____ 16. **I understand that if I fail to comply with the guidelines in this agreement and on my prescription labels; if I obtain narcotics elsewhere (even from a physician); if I use illicit drugs; if I share narcotics with others; or if I alter a prescription, our doctor-patient relationship will be terminated.**

I have read this agreement. I fully understand the consequences of violating this agreement. I fully accept these terms and conditions.

Patient name: _____

Patient signature and date: _____

Witness signature and date: _____

□ Copy given to patient

Concord Family Practice

Narcotic Policy

This notice is for all NEW patients. It is our office policy that under any circumstances will we write any prescriptions that are considered a controlled drug by the FDA. This applies to all NEW patients. The following among many more are included and WILL NOT be written by any of our physicians.

- Ambien
- Xanax
- Adderall
- Valium
- Codeine Drugs
    - Hydrocodone
    - Phenergan w/ Codiene
    - Cough syrup w/Codiene
    - Oxycodone
    - Etc.
- Morphine
- Saboxone
- Etc.

By signing this document you are stating that you are fully aware of our narcotic policy and will not request or be seen for such.

SIGNATURE OF PATIENT

DATE SIGNED