TRI-COUNTY PAIN CARE
JAY M. MERGAMAN, MD

Tel: 215-830-0530
Fax: 215-830-0542

RECORD RELEASE AUTHORITY

TO: _____

FAX: _____

TEL: _____

I, _____ hereby request that all medical reports, records, test results, radiology studies, as well as any data pertinent to my care be released to:

TRI-COUNTY PAIN CARE
JAY M. MERGAMAN, M.D.
3501 MASON'S MILL RD, SUITE 501
HUNTINGDON VALLEY, PA 19006

_____
(DATE OF REQUEST)

_____
(PATIENT'S SIGNATURE)

_____
(PATIENT'S DATE OF BIRTH)

Abington Health
Lansdale Hospital
100 Medical Campus Dr
Lansdale, PA 19446

Valley Pain Center
Mason's Mill Business Park II
1800 Byberry Rd, Ste 1101
Huntingdon Valley, PA 19006

Mason's Mill Business Park I
3501 Masons Mill Rd
Bldg 5, Ste 501
Huntingdon Valley, PA 19006

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MEMBER CONSENT FOR FINANCIAL RESPONSIBILITY FOR UNREFERRED/NON-COVERED SERVICES

MEMBER INFORMATION

PLAN NAME: _____ **NUMBER:** _____

MEMBER NAME: _____ **SOCIAL SECURITY NUMBER:** _____

AS A MEMBER OF THE INSURANCE PLAN NAMED ABOVE, I UNDERSTAND THAT:

____ A referral form from my Primary Care Physician is required for any and all non-emergency outpatient hospital/specialist services. I acknowledge that if I do not have a referral form at this time, but I choose to receive services from Tri-County Pain Care without the required referral, I will be financially liable for any charges incurred for these services.

____ I understand that if this is a non-covered service for which my insurance carrier will not make Payment and I agree to be financially liable for any charges incurred for these services.

____ I understand that certain services are not covered when performed in an office and /or hospital setting. If I choose to receive these services in a provider's office, rather than the appropriate Network setting, I agree to be financially liable for any charges incurred for these services.

_____ _____

(MEMBER'S SIGNATURE) (DATE)

_____

(WITNESS)

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NOTICE OF PRIVACY PRACTICES

To Our Patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our Commitment to Your Privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and Disclosure of Your Health Information In Certain Special Circumstances
The following circumstance may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual, or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To Federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers' Compensation and similar programs.

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Your Rights Regarding Your Health Information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to *Tri-County Pain Care, P.C.*

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to *Tri-County Pain Care, P.C.* You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact *Tri-County Pain Care, P.C.*

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact *Tri-County Pain Care, P.C.* All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact *Tri-County Pain Care, PC.*

I hereby acknowledge that I have been presented with a copy of Tri-county Pain Care's Notice of Privacy Practices.

(SIGNATURE OF PATIENT)	(PRINT- NAME OF PATIENT)	(DATE)

Jay M. Mergaman, M.D.
Pain Management Agreement

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

- 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 if I break this Agreement I will be discharged from Tri-County Pain Care. Also, a drug-dependence treatment program may be recommended.
- I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.
- I will not use any illegal controlled substances, including marijuana, cocaine, etc.
- I will not share, sell, or trade my medication with anyone.
- I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor.
- I will safeguard my pain medicine from loss or theft. Lost or stolen medicines **will not be replaced.**
- I will agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. **No refills will be available during evenings or on weekends.**
- I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
- I **agree** that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.
- I **agree** that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
- I agree to use _____**Pharmacy, located at**_____ **Telephone number** _____ for filling prescriptions for **all of my pain medications.**
- I **agree** to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this ___day of_____, _____

Patient Signature: _____

Physician signature: _____