PATIENT DEMOGRAPHIC INFORMATION

LAST NAME: ___________________________ FIRST: ___________________________ MI: ______

PREFERRED NAME (IF APPLICABLE): _______________________DATE OF BIRTH:______________

HOME STREET ADDRESS: ____

CITY: ____ ZIP CODE: ________________________

PREFERRED PHONE NUMBER: ____

▢ CHECK BOX TO AUTHORIZE TEXT MESSAGING COMMUNICATION (CARRIER RATES MAY APPLY)

▢ CHECK BOX IF OKAY TO LEAVE DETAILED MEDICAL INFORMATION ON THIS VOICEMAIL

EMAIL ADDRESS: ____

PRIMARY CARE DOCTOR: ____

PRIMARY CARE DOCTOR'S PHONE NUMBER (if known): _________________________________

PHARMACY NAME: ____

PHARMACY CITY: _______________________________________

PHARMACY ADDRESS (IF MULTIPLE LOCATIONS):_______________________________________

EMERGENCY CONTACT

EMERGENCY CONTACT NAME: ____

EMERGENCY CONTACT PHONE NUMBER: ____

RELATIONSHIP TO PATIENT: ____

▢ CHECK BOX IF OKAY TO SHARE HEALTH INFORMATION WITH THIS PERSON

LIST ANY OTHER PEOPLE APPROVED TO DISCUSS HEALTH INFORMATION:

NAMES: ____

NOTICE OF HIPAA POLICY AND PROCEDURES

SIGN BELOW THAT YOU HAVE REVIEWED A COPY OF THE ECPC HIPAA POLICY AND PROCEDURES

SIGNATURE: ______________________________________ DATE: __________________________

As the patient or responsible party, I hereby consent to receiving emails and auto-dialed and/or artificial or pre-recorded collection or health-care related message calls and text messages to my email, cellular phone number and any other telephone numbers, as applicable, provided during any interaction, agreement or communication with the facility, its independent contractors, and/or their affiliates, agents and contractors, including any of their billing or account management companies and/or debt collectors. **(*This allows our billing company to send a text link for paying your bill)***

SIGNATURE: ______________________________________ DATE: __________________________

ECPC PAIN SPECIALISTS

CONFIDENTIAL HEALTH HISTORY FORM

(Yes we know it's a lot, but complain to your insurance company, that is why it's long…)

Patient Name:_______________________________________ **Date of Birth:**______________ **Today's Date:**______________

Who referred you (sent you) to this office?:____

What is the main reason you are here today?:____

1. When did the pain start?: (Approximate MM/DD/YR) ____/_____/_____

2. Briefly describe how this started (for example: A specific injury, car accident, nothing specific, etc.):

____

____

3. Location of pain: ☐Face ☐Neck ☐Upper back ☐Arm/hand ☐Chest ☐Lower back ☐ Hip ☐ Knee ☐Leg ☐Foot ☐ Other:_______

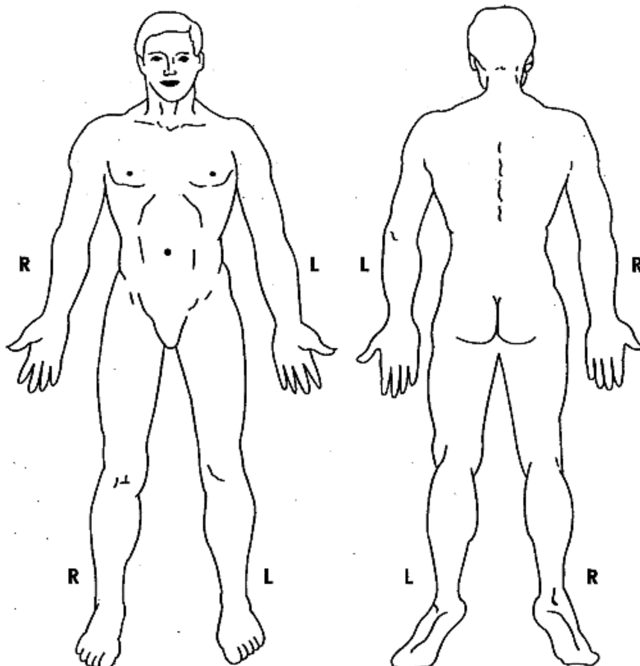
4. If you have pain on both sides, is one worse?:
☐ Right ☐ Left ☐ Same

5. Choose your ONE worst area: ☐Face ☐Neck ☐ Upper back ☐Arm/hand ☐ Chest ☐ Lower back ☐ Hip ☐ Knee ☐ Leg ☐ Foot ☐Other:___________

6. How does the pain feel?: ☐Burning ☐Aching ☐ Throbbing ☐ Pins and needles ☐ Sharp/stabbing

7. How often do you feel pain?: ☐ Constant ☐ Off and on

8. <u>Mark the areas on the diagram where you feel pain:</u>



9. ***Your AVERAGE PAIN over the last week*:**
<u>0=none, 10=worst possible</u>

☐ 0 ☐ 1 ☐2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

10. ***How much has pain interfered with your ENJOYMENT OF LIFE over the last week?***
<u>0=none, 10=completely</u>

☐ 0 ☐ 1 ☐2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

11. ***How much has pain interfered with your GENERAL ACTIVITY over the last week?***
<u>0=none, 10=completely</u>

☐ 0 ☐ 1 ☐2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

12. <u>Check off anything that makes your pain better or worse (leave blank if no effect):</u>

	Less Pain	**More Pain**
Sitting	☐	☐
Standing	☐	☐
Walking	☐	☐
Bending forward	☐	☐
Lying on back	☐	☐
Lying on stomach	☐	☐
Lying on your side	☐	☐
Rising from sitting	☐	☐
Changing positions	☐	☐
Coughing/sneezing	☐	☐
Other:	☐	☐

13. Check off any treatments you have tried or are using for your pain:

A. NSAIDs: (Mark any tried below) ☐**None**

☐Ibuprofen	☐Aspirin	☐Naproxen	☐Meloxicam	☐Nabumetone
☐Celecoxib	☐Diclofenac	☐Ketorolac(Toradol)	☐Indomethacin	

B. Muscle relaxers: (Mark any tried below) ☐**None**

☐Baclofen	☐Cyclobenzaprine	☐Methocarbamol	☐Tizanidine
☐Metaxalone	☐Orphenadrine	☐Diazepam(Valium)	☐Carisoprodol(Soma)

C. Opioids (narcotics): (Mark any tried below) ☐**None**

Short acting:	☐Tramadol	☐Hydrocodone(Norco)	☐Morphine	☐Oxycodone(Percocet)
☐Hydromorphone(Dilaudid)	☐Nucynta IR	☐Oxymorphone(Opana IR)	☐Codeine	

Long acting:	☐Tramadol ER	☐Hydrocodone(Zohydro, Hysingla)	☐Nucynta ER
☐Hydromorphone(Exalgo)	☐Oxymorphone (Opana ER)	☐Oxycodone(Oxycontin, Xtampza)	☐Belbuca
☐Butrans	☐Fentanyl patch	☐Morphine(MS Contin, Embeda)	
☐Levorphanol	☐Methadone	☐ Buprenorphine tabs/films(Suboxone)	

D. Nerve pain medicines: (Mark any tried below) ☐**None**

☐Amitriptyline	☐Nortriptyline	☐Gabapentin	☐Pregabalin (Lyrica)
☐Topiramate (Topamax)	☐Duloxetine (Cymbalta)	☐Carbamazepine (Tegretol)	☐Oxcarbazepine (Trileptal)
☐Phenytoin (Dilantin)	☐Lamotrigine(Lamictal)	☐Lacosamide(Vimpat)	☐Venlafaxine(Effexor)
☐Milnaciprin(Savella)	☐Levetiracetam(Keppra)	☐Gabapentin ER (Horizant, Gralise)	

E. Migraine medicines (if applicable): (Mark any tried below) ☐**None**

☐Sumatriptan(Imitrex)	☐Rizatriptan(Maxalt)	☐Eletriptan(Relpax)	☐Zolmitriptan(Zomig)
☐Botox	☐Emgality	☐Ajovy	☐Fioricet(Butalbital/combo)
☐Propranolol	☐Nurtec	☐Qulipta	☐Ubrelvy

F. Other medicines: (Mark any tried below) ☐**None**

☐Acetaminophen(Tylenol)	☐Oral steroid(prednisone)	☐Clonidine	☐Naltrexone	☐Ropinirole	☐Pramipexole

G. Topical (on the skin) medications/treatments: (Mark any tried below) ☐**None**

☐Lidocaine (Lidoderm, ZTLido)	☐Icy Hot/Bengay	☐Diclofenac gel (Voltaren gel)	☐Heat/Ice	☐TENS unit

H. Injections and procedures: (Mark any tried below) ☐**None**

☐Epidural	☐RFA/Nerve burning	☐Sacroiliac injection	☐Knee injection	☐Hip injection
☐Shoulder injection	☐Trigger point injection	☐Pain pump	☐Spine stimulator	

I. Exercise or other therapies: (Mark any tried below) ☐**None**

☐Home exercises from doctor or therapist	☐Chiropractic	☐Psychological treatments

☐Physical or Aquatic Therapy: *Dates:* ______________________________ *Location:* ______________________________

J. Other treatments: ☐______________________________ ☐ ______________________________

14. Function: Check off any items that are negatively affected due to pain:

☐ Chores at home ☐ Working ☐ Exercising ☐ Grooming yourself ☐ Your Mood ☐ Sleeping
☐ Walking ☐ Your relationships with others ☐ Sexual activity ☐ Driving

15. What would you like to do if your pain didn't stop you (for example: exercise 3 times per week, play with your kids or grandkids on the ground, work longer, hike, fish, hunt, etc.)?

1. ____

2. ____

16. Past Medical History: Check off any of the following diseases that a doctor has diagnosed you with in the past:

☐Anemia
☐Asthma
☐Autoimmune disease
☐Type:________________________
☐Bipolar disorder
☐Bleeding disorder
☐Cancer
☐Congestive heart failure
☐COPD
☐Depression
☐Diabetes
☐Fibromyalgia
☐Gout
☐Heart disease/heart attack
☐Hepatitis/liver disease
☐High blood pressure
☐HIV or AIDS
☐Kidney disease
☐Migraines
☐Osteoporosis
☐Reflux
☐Stomach ulcers
☐Seizure disorder/epilepsy
☐Stroke
☐Sleep apnea
CPAP/BiPAP used: ☐Yes ☐No
☐Other:________________________
☐Other:________________________
☐Other:________________________

17. Past Surgical History: Check off any surgeries you have had, and write the approximate date if known:

☐Lumbar spine surgery Date:_________________
☐Cervical spine surgery Date:_________________
☐Knee Replacement ☐Right Date:_________________
☐Left Date:_________________
☐Hip replacement ☐Right Date:_________________
☐Left Date:_________________
☐Other:_________________________ Date:__________
☐Other:_________________________ Date:__________
☐Other:_________________________ Date:__________
☐Other:_________________________ Date:__________
☐Other:_________________________ Date:__________

18. Review of Systems: Check off any symptoms you have experienced in the last 30 days:

Constitutional
☐Chills
☐Fatigue
☐Fever
☐Night sweats
☐Unexplained weight loss

Respiratory
☐Shortness of breath

Cardiovascular
☐Pain in legs when walking
☐Swelling (Edema)
☐Palpitations

Genitourinary
☐Urinary incontinence
☐Men only- Erectile dysfunction

Allergic/immunologic
☐Hives
☐Anaphylaxis

GI/Digestive
☐Abdominal pain
☐Constipation
☐Diarrhea
☐Heartburn
☐Nausea
☐Vomiting

Neurological
☐Dizziness
☐Limb/Extremity numbness
☐Limb/Extremity weakness
☐Gait disturbance
☐Headache
☐Seizures

Endocrine
☐Heat intolerance
☐Cold intolerance

Eyes
☐Double vision

Psychiatric/Mental Health
☐Anxiety
☐Depression
☐Insomnia
☐Suicidal thoughts

Musculoskeletal
☐Joint pain
☐Joint swelling

Hematologic/lymph
☐Easy bleeding
☐Easy bruising
☐Swollen glands (Lymphadenopathy)

Ears, nose, mouth, throat
☐Food sticking in throat

Integumentary/Skin
☐Rash

19. Check off if you are allergic to any of the following:

- ☐ Latex
- ☐ Anesthetic
- ☐ Shellfish/seafood
- ☐ IV Contrast Dye
- ☐ Betadine/Iodine

Other allergies:

- ☐ ____
- ☐ ____
- ☐ ____
- ☐ ____

20. Check off any of the following medications you are currently taking:

☐ **Clopidogrel (Plavix)** ☐ **Rivaroxaban (Xarelto)** ☐ **Aspirin** ☐ **Dabigatran (Pradaxa)** ☐ **Warfarin (Coumadin)**
☐ **Apixaban (Eliquis)** ☐ **Cilostazol (Pletal)** ☐ **Effient (Prasugrel)** ☐ **Aggrenox (Aspirin/dipyramidole)**

***** Please provide a copy of all your medications, or complete our medication list form if you do not have one and it was not sent***

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21. Family History: Check off any medical problems your family members have been diagnosed with:

☐ I am adopted and unknown history

Parents	**Brother or Sister**	**Son or Daughter**
☐Heart problems	☐Heart problems	☐Heart problems
☐High blood pressure	☐High blood pressure	☐High blood pressure
☐Diabetes	☐Diabetes	☐Diabetes
☐Lupus	☐Lupus	☐Lupus
☐Ankylosing spondylitis	☐Ankylosing spondylitis	☐Ankylosing spondylitis
☐Rheumatoid arthritis	☐Rheumatoid arthritis	☐Rheumatoid arthritis
☐Cancer	☐Cancer	☐Cancer
☐Other:_________________________	☐Other:_________________________	☐Other:_________________________
☐Other:_________________________	☐Other:_________________________	☐Other:_________________________

Social History: Please answer the following questions:

22. Tobacco use: ☐ None ☐ Current tobacco user ☐ Former tobacco user: Age quit:_________________

Type: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Vaporizer ☐ Smokeless tobacco ☐ Other:____________________

23. Alcohol use: ☐ None ☐ Regular, amount per week:_____________ ☐ Rare, amount per month:______________

☐Other: ____

Do you have a history of alcoholism?: ☐ No ☐ Yes

24. Street Drug use: ☐Never ☐None in longer than 5 years ☐Yes but quit within last 5 years

☐Yes, current (select): ☐ Marijuana ☐ Cocaine ☐ Methamphetamine ☐ Heroin ☐ Other: _________________

25. Marital status: ☐ Married ☐ Partner ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

26. Education: Highest grade/degree obtained ____________________________________

27. Working status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Homemaker ☐ Student ☐ Disabled, since:________

Occupation or former occupation:____

Medication Reconciliation List (IF NEEDED)

If we do not have a list of your medications, please complete this form to the best of your ability.

Medication Name	Strength	Frequency (how often you take it)
ex: Acetaminophen	*500mg*	*2 tabs 2 times per day*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement **which most clearly describes your problem.**

Section 1: Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. washing, dressing)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but can manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives me extra pain
- ☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
- ☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights
- ☐ I cannot lift or carry anything

Section 4: Walking*

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 2 kilometres
- ☐ Pain prevents me from walking more than 1 kilometre
- ☐ Pain prevents me from walking more than 500 metres
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5: Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6: Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7: Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9: Social Life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10: Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

ECPC
PAIN
SPECIALISTS
Division of East Carolina Anesthesia Associates, PLLC

Please mark each question either Yes or No.

		Yes	No
1	Does your family have a history of alcoholism?	☐**Yes**	☐ **No**
2	Does your family have a history of illegal drug use?	☐**Yes**	☐**No**
3	Does your family have a history of prescription drug addiction?	☐**Yes**	☐**No**
4	Do you have a history of alcoholism?	☐**Yes**	☐**No**
5	Do you have a history of illegal drug use?	☐**Yes**	☐**No**
6	Do you have a history of prescription drug addiction?	☐**Yes**	☐**No**
7	Is your age between 16 - 45 years old?	☐**Yes**	☐**No**
8	Did you experience sexual abuse as a child?	☐**Yes**	☐**No**
9	Do you have a history of Attention Deficit Disorder (ADD or ADHD), bipolar or schizophrenia?	☐**Yes**	☐**No**
10	Do you have a history of depression?	☐**Yes**	☐**No**

ECPC
PAIN SPECIALISTS
Division of East Carolina Anesthesia Associates, PLLC

AUTHORIZATION TO RELEASE HEALTH RECORDS AND INFORMATION

Patient Name: ________________________________ Date of Birth: ________________

Address: ____

City, State, Zip: ____________________________ Phone #: _____________________

Company to release information:

Name: ____

Address: ____

City, State, Zip: ____________________________ Phone #: _____________________

Information to release (please check):

❒ Entire Records ❒ Lab Reports ❒ Office Notes ❒ Radiology Reports ❒Other: _____________

Dates of records to be released (please select):

From:____________________ To:____________________ ❒Last 2 years **❒All Dates**

Purpose Of Disclosure (please check):

❒Continuing Care ❒ Personal Use ❒Legal Investigation ❒ Insurance ❒Other: _______________

Release requested information to:

ECPC Interventional Pain and Spine
333 Earnie Lane
Holly Springs, NC 27540
T: 984-777-8787 F: 984-777-9202

Review and approval: I understand that the information to be released may include reference to sensitive information related to mental and behavioral health, genetic testing, HIV/AIDS or other communicable diseases, and drug or alcohol abuse. I specifically approve the release of the following information that has been marked as sensitive and/or restricted (Check all that apply)

❒ Mental and Behavioral Health ***❒Substance Abuse*** ***❒Genetic Testing***

I understand that I may revoke this Authorization in writing at any time, except to the extent that action has already been taken in response to the Authorization. I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy law. I understand that I may refuse to sign this Authorization. If I do not sign this Authorization, ECPC will continue to provide treatment and seek payment for services provided. ECPC may charge a fee for providing the information specified above.

This Authorization will automatically expire one year from the date signed below unless revoked or another date or event is written here:

______________________________________ ______________________________
Signature of Individual or Guardian/Estate Representative Date

____
Relation of Guardian or Estate Representative

333 Earnie Lane
Holly Springs, NC 27540

6905 Knightdale Blvd, Ste 105
Knightdale, NC 27545

ECPC Pain Specialists complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Notice of Privacy Practices

Effective Date: 7/1/2017

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.

If you have any questions about this notice, please contact Doug Frankey at 252-752-2140.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval

process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.
Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.
National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.
Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we are practically able.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to ECPC Pain Specialists, 333 Earnie Lane, Holly Springs, NC 27540. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an Electronic Medical Record or an Electronic Health Record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every

effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.
Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to ECPC Pain Specialists, 333 Earnie Lane, Holly Springs, NC 27540.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to ECPC Pain Specialists, 333 Earnie Lane, Holly Springs, NC 27540.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse.
To request a restriction, you must make your request, in writing, to ECPC Pain Specialists, 333 Earnie Lane, Holly Springs, NC 27540. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to ECPC Pain Specialists, 333 Earnie Lane, Holly Springs, NC 27540. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.ECPC1.com. To obtain a paper copy of this notice, submit your request to ECPC Pain Specialists, 333 Earnie Lane, Holly Springs, NC 27540.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Doug Frankey. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-252-561-8218.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-252-561-8218.