DIMURO PAIN MANAGEMENT

PATIENT ATTESTATION

PLEASE READ THIS SECTION CAREFULLY ALONG WITH THE DOCUMENTS THAT ARE REFERENCED.

Thank you for choosing DiMuro Pain Management. Please make sure you have received all documents listed below. It is important that you carefully read and review these documents before your consultation with our pain management Physician. Please initial your name once you have read, understood, and agreed with each of the documents completely. The documents listed below are used for your benefit to inform you in regards to our policies & procedures.

1. Policy Concerning Advance Directives
I was given information about the organization's *Advance Directives/Consent to Resuscitative Measures* policy. Any questions, concerns, and/or disagreements to these terms will be my responsibility to bring to the attention of appropriate staff.
If you have an Advanced Directive, did you bring a copy with you today? **Yes** ___ **No**___
Initials _____

2. Privacy practices, Privacy Notice and HIPPA compliant release
I was given and have read, understand, and agree with the organization's *Privacy Notice and privacy policies* (this notice is located in the procedure waiting room and on the www.dimuropain.com website). I was given and have read, understand, and agree with the organization's HIPPA compliant release and have completed the release form.
Initials _____

3. Patient's Rights and Responsibilities
I was given and have read, understood, and agree with the organization' patient's rights and responsibilities located in the procedure waiting room and on the website. Included in this information was a list of contact information regarding where and to whom I may be able to express my concerns, complaints, and/or grievances.
Initials _____

4. Medical Lien Agreement/Assignment of Benefits
I was given and have read, understood and agree with the Medical *Lien Agreement/Assignment of Benefits* given to me by the organization. Any questions, concerns, and/or disagreements to these terms will be my responsibility to bring to the attention of the appropriate staff and/or my attorney.
Initials _____

5. Opioid Contract and Patient Medication list
I was given (during the initial consultation), understood, and agree that if I was to violate any of the condition(s) written in the *Opioid Contract*, given to me by the organization, that it may result in dismissal from this practice and the discontinuation of getting any narcotics/controlled substances prescribed to me. I have honestly and completely disclosed any and all medications including prescription, over the counter, supplements and herbal with dosage, frequency, and reason for taking. **Initials** _____

6. General Consent for Treatment and Procedural Consent
I was given and have read, understood, and consent generally and to the procedure for which I am to undergo. The physician has explained and I understand the purpose for and am in agreement. If I have any questions it is my responsibility to ask them prior to the preparation for the procedure.
Initials _____

I understand that me and/or if applicable, my attorney will receive all signed documents included in this packet (see medical lien/assignments of benefits agreement)**.** □ I would like copies □ I do not want copies

Disclosure of Physician Ownership:
I understand that DiMuro Facilities Services LLC is owned 100% by Dr. John DiMuro, DO. Any questions and/or concerns will be my responsibility to address with appropriate staff.
Initials _____

I certify that I have received written documentation of the items list above, prior to my scheduled initial consultation and/or my procedure date. By signing below, I understood and agreed to the above documents, including with regards to DiMuro Pain Management policies and procedures. I am also validating that the initials next to each of the corresponding documents, listed above, were written by me. Furthermore, I have understood that should I have any questions regarding its content, I should contact appropriate management or staff for any clarification.

_____	_____	_____
Signature	**Printed Name**	**Date**

DIMURO PAIN MANAGEMENT

Advanced Directives Policy and Consent to Resuscitative Measures

Not a Revocation of Advanced Directives or Medical Powers of Attorney

All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Powers of Attorney that authorize others to make decisions on their behalf based of the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. DPM respects and upholds those rights.

However, unlike in an acute care hospital setting, DPM does not routinely perform "high risk" procedures. While no surgery is without risk, the procedures performed in this facility are considered to be of minimal risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks and expected recovery and care after the procedure.

Therefore, it is our policy, regardless of the contents of and Advanced Directives or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during your treatment we will initiate resuscitative or other stabilizing measures and transfer you to a hospital for further evaluation. At the acute care hospital further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or Health Care Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current Health Care Directive or Health Care Power of Attorney.

If you do not agree to this policy, we recommend you reschedule the procedure.

Please check the appropriate box:

- ☐ Yes, I have an Advance Directive, Living Will or Health Care Power of Attorney.
  - ☐ *I have provided a copy of such document to be part of my medical record.*
  - ☐ *I have **not** provided a copy of such document to be part of my medical record.*
- ☐ No, I do not have an Advance Directive, Living Will or Health Care Power of Attorney.

I understand that DNR (do not resuscitate) orders will be suspended during the procedure until I completely recover from the effects of anesthesia.

I acknowledge that I have read and understand the contents above and agree to the policy as described:

By:_____ Witnessed By:_____

(Patient's Signature) (Witness Signature)

If other than patient, relationship: _____

Patient's Last Name:	Patient's First Name:	Date:

DIMURO PAIN MANAGEMENT

DEFINITIONS

A. **Agent** – A person appointed to make medical decision for someone else, as in a Durable Power of Attorney for Health Care (also called a surrogate or proxy).

B. **Attending Physician** – The physician selected by or assigned to a patient who has primary responsibility for the treatment and care of the patient. When more than one physician shares such responsibility, any such physician may act as the attending physician.

C. **Advance Directive** – A document in which a person either states choices for medical treatment or designates who should make treatment choices if the person should lose decision-making capacity. Examples of these documents are a Living Will and Durable Power of Attorney for Health Care.

D. **Decision-Making Capacity** – The ability to make choices that reflect an understanding and appreciation of the nature and consequences of one's actions and the patient has not been declared incapacitated by any court nor has a guardian been appointed over his or her person.

E. **Declaration** – An Advance Directive.

F. **Durable Power of Attorney for Health Care (DPAHC)** – An Advance Directive in which an individual names someone else (the "agent" or "proxy") to make health care decisions in the event the individual becomes unable to make them himself or herself. The DPAHC can also include instructions about specific healthcare choices to be made.

G. **Living Will** – A written document executed by the patient directing that should the patient have a terminal condition, life-sustaining procedures will be withheld or withdrawn.

H. **Directive for Final Healthcare** – A written document executed by the patient that combines the Durable Power of Attorney for Health Care and Living Will documents.

DIMURO PAIN MANAGEMENT

OPIOID AGREEMENT FORM

Patient Name: _____

Medical Record Number: _____

AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

The use of _____ (print names of medication(s)) may cause addiction and is only one part of the treatment for: _____ (print name of condition-e.g., pain, inflammation, etc.).

The goals of this medicine are:

- ☐ to improve my ability to work and function at home.
- ☐ to help my_____ (print names of condition-e.g., pain, inflammation, etc.) as much as possible without causing dangerous side effects.

I have been told:

1. if I drink alcohol, marijuana or use street drugs, I may not be able to think clearly, and could become sleepy and risk personal injury.
2. I may get addicted to this medication.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, I must do it slowly or I may get very sick.

I agree to the following (please initial):

_____ I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else's medicine.

_____ I will not increase my medicine until I speak with my doctor or nurse.

_____ My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.

_____ I will keep all my appointments set up by my doctor (e.g., primary care, physical therapy, mental health, substance abuse treatment, pain management)

_____ I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.

_____ I agree to give a blood or urine sample, if asked, to test for drug use.

Refills

Refills will be made only during regular office hours- Monday through Friday, 9:00AM-5:00 PM.
No refills on nights, holiday, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. **No exceptions will be made.** I must keep track of my medications. No early or emergency refills may be made.

Pharmacy

I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines.

The name of my pharmacy is: _____ Location: _____

Prescription from Other Doctors

DIMURO PAIN MANAGEMENT

If is see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to DPM in the original bottle, even if there are no pills left.

Privacy

While I am taking this medication, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medication. I will be asked to sign a release at that time.

Termination of Agreement

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way. I have talked about this agreement with my doctor and I understand the rules stated in this agreement.

Provider Responsibilities

As your doctor, I agree to perform regular checks to see how well the medicine is working. I agree to provide care for you as needed that may not involve getting controlled medicines from me.

☐ Please check here if you would like a copy of this agreement.

_____ _____

Patient's Signature Date

_____

Patient's printed name

_____

Physician's Signature

Dr. John DiMuro

DIMURO PAIN MANAGEMENT

Patient Home Medication List (As Provided by Patient)

- ☐ No known Allergies
- ☐ Allergies to food, medication (including latex or IV contrast) etc: (Please list each and their reactions)

_____

_____

_____

Please include all medications (including prescription, over the counter, vitamins, supplements, herbal, street drugs etc).

Name 	Dose	Frequency (How often?)	Reason for Taking	Date of Visit: _____ Last time taken (Date/Time)	C=Continue upon Discharge D=Discontinue upon discharge

Physician Orders:

Discharge Medication	Dosage	Frequency	Comments

Physician/Staff signature:_____Date:_____Time:_____

Patient Signature: _____Date:_____Time:_____

DIMURO PAIN MANAGEMENT

Pre-Procedure Questionnaire

Instruction to Patient: Please print or indicate by a check mark (✓) your answer to each question.

Name_____**Age**_____**Sex**_____**D.O.B.**_____

Height _____**Weight (lbs.)** _____**Right-handed** ☐ **Left-handed** ☐

List all previous surgeries (and when):

_____

_____

_____

Yes	No	
☐	☐	Have you or your family had a high or unexplained fever (hyperthermia) during or after surgery?
☐	☐	Have you or your family had any unusual reaction to anesthesia?
☐	☐	Have or are you taking "street" drugs? If yes, last date taken _____
☐	☐	Do you use Medical Marijuana? If yes, last date:_____
☐	☐	Have you had recent weight change (significant amount)?
☐	☐	Are you pregnant?
☐	☐	Do you smoke? If yes, (how many)_____cigarettes per day.
☐	☐	Do you drink alcoholic beverages? If yes, How much_____, last time_____
☐	☐	Have you taken any of the following medications? (Please circle any taken in the last week) Aspirin, Plavix, Coumadin, Anti-inflammatory
☐	☐	Have you ever experienced any reaction to rubber or latex products? If yes, please describe: _____
☐	☐	Do you have any implanted devices (pacemaker, pins, etc.)?

Do you or have you ever had any of the following?

Yes	No		Yes	No	
☐	☐	Glaucoma	☐	☐	Stroke
☐	☐	TMJ (dysfunction of temporomandibular joint)	☐	☐	Seizures
☐	☐	Stiff neck or jaw	☐	☐	Blackouts
☐	☐	Shortness of breath	☐	☐	Muscle disease
☐	☐	Asthma	☐	☐	Arthritis
☐	☐	Chronic cough	☐	☐	Diabetes
☐	☐	A cold in the past month	☐	☐	Thyroid problems
☐	☐	Heart attack	☐	☐	Bleeding tendencies
☐	☐	Chest pain; Angina	☐	☐	Sickle Cell Anemia
☐	☐	Palpitations	☐	☐	Blood transfusions
☐	☐	High Blood pressure	☐	☐	Kidney Disease
☐	☐	Hepatitis? If yes, type ☐A ☐B ☐C	☐	☐	Aids/HIV Positive
☐	☐	Hiatal Hernia	☐	☐	Others (please describe)
☐	☐	Rheumatic Fever	_____		
☐	☐	Ulcers	_____		

DIMURO PAIN MANAGEMENT

GENERAL CONSENT FOR TREATMENT

PATIENT NAME: _____ **DOB:** _____
(*Full Legal Name)*

DATE OF INJURY:_____ **ATTORNEY:**_____

Consent to Treatment
I consent to the procedures that may be performed during my stay at DiMuro Pain Management or "DPM" on an outpatient basis, which may include but are not limited to: Laboratory procedures, diagnostic procedures, x-ray examination, anesthesia, medical, or surgical treatment or procedures. Female patients will be tested for pregnancy unless they have not had a menstrual period in 5 years or have had a hysterectomy OR unless pregnancy testing is declined by patient.
Your treating physician is: ☐ Dr. John DiMuro, DO ☐ Other_____

Photography
I understand healthcare providers at DPM may use photographs, films or other recordings for identification, diagnosis, treatment, education, or for any other healthcare purposes. Any other uses will require my authorization. Additionally, I grant authorization by DPM to use any images for educational purposes.

Informed Consent
DR. JOHN DIMURO, anesthesiology and pain medicine is responsible for obtaining my informed consent before any proposed medical services or surgical procedures are performed. If I am unable to consent to treatment, Dr. DiMuro is responsible for obtaining consent from my legal guardian or representative.

Financial Agreement
I understand I am fully liable for the total cost of the care and services that I receive, at the rate effective on the date received, regardless of whether any insurance proceeds or settlement funds are available to pay for them.

I am responsible for payment of any services received for this date of service. I understand that no health insurance is accepted in any way as payment for services received today.

I understand that if care and services are received as a result of an injury for which I receive a monetary award, settlement or verdict and that if the amount I receive will not pay the balance on the account, that DiMuro Professional Services, LLC and DiMuro Facilities Services, LLC, DBA DiMuro Pain Management or "DPM" will accept the amount I receive as a partial payment and that acceptance of a partial payment will not discharge my financial obligation for the remaining balance.

Retention
DPM, will retain the financial details of my account for the period required by law. Medical records of patients over the age of 18 will be destroyed after 5 years. Medical records of patients under the age of 18 will be destroyed 5 years after the patient reaches the age of 18.

Assignment of Benefits
I assign to DPM, all applicable benefits otherwise payable to me not to exceed the established charges for the services provided. I except financial responsibility for any charges not paid by the assignment.

Release of Information
I acknowledge that DPM, the physicians and other health professionals involved in my care will share healthcare information necessary for treatment, payment or healthcare operations as allowed by law. Information may be released to any person or entity liable for payment on my behalf to verify coverage, answer payment questions or for any other purpose related to benefit payment.

Communications about my health

DIMURO PAIN MANAGEMENT

Unless I request privacy restrictions, I understand my healthcare information may be disclosed for purposes of communicating results, findings and care decisions to my family members and others responsible for my care as designated by me. My name, location and condition will be available to them by visits from medical personnel, phone calls, or other directory services.

Other acknowledgement

I understand that providers furnishing services may be independent contractors and not employees or agents of DPM. Independent contractors are responsible for their own actions and DPM is not liable for the acts or omissions of any independent contractor. Independent contractors may bill separately for their services. I understand physicians or other healthcare professionals may be called upon to provide care or services to me on my half, but I may not actually see or be examined by such physicians or healthcare professionals participating in my care. For example, I may not see physicians providing anesthesiology or radiology services.

Personal Valuables

I understand DPM, maintains lockers for the safe keeping of money and valuables for patients who are admitted to the procedure center. DPM is not responsible for the loss or damage to any money, jewelry, glasses, dentures, or any other item that would be considered a loss if misplaced, and not deposited within their designated locker for specifics of safe keeping. I agree to reclaim any property in custody of this entity within 60 days of discharge. If I am unable to sign for the release of said property, my personal representative may reclaim the property.

Patient printed name: _____ Date: _____ Time:_____

Patient Signature: _____

Witness printed name: _____ Date: _____ Time:_____

Witness Signature: _____

DIMURO PAIN MANAGEMENT

CONSENT FOR INTERVENTIONAL PAIN PROCEDURE

I hereby acknowledge that I have been informed of the nature of the proposed procedure:

_____

_____

_____

It has been explained to me, either by my physician and/or through a translator, that complications may occur both during and after the procedure. Complications common to all pain procedures, include but are not limited to the following:

1) Bleeding or hematoma in the spine causing permanent damage to the nerves and or spinal cord
2) Infection at the injection site or at any other site in the body including the spine
3) Allergic reaction to the scrub solution or medications injected
4) Seizure
5) Heart irregularities
6) Spinal cord and/or spinal nerve injury
7) Peripheral nerve injury
8) Irregular sensations during needle placement
9) Headache
10) Numbness and/ or weakness of the arms and/ or legs
11) Pain and spasms during and/or after the procedure
12) _____
13) _____

The risks, benefits and alternatives to the proposed procedure have been explained to my satisfaction. I am aware that the procedure may not provide pain relief to my satisfaction. I have read this document in its entirety and/or had it appropriately translated for me and have had sufficient opportunity to discuss any concerns I may have with the physician who will be performing the procedure. All my questions have been answered to my satisfaction and I choose to proceed with the procedure. I have been informed that fluoroscopy (live x-ray/radiation) will be used during the procedure.

For Female patients:

☐ **I certify that I am not and cannot possibly be pregnant at this time and consent to the use of x-ray.**
Date of last period: _____ ☐ I have had a hysterectomy (date): ___/___/____ ☐

☐ **I understand that DFS uses Versed for conscious sedation and that it has a black box warning for pregnancy and newborns.**

_____	_____	_____	_____
Patient Printed Name	Patient Signature	Date	Time
Dr. John DiMuro, DO	_____	_____	_____
MD Printed Name	MD/DO Signature	Date	Time
_____	_____	_____	_____
Witness Printed Name	Witness Signature	Date	Time

Authorization for designated responsible adult

I request and authorize that the person(s) designated below be allowed to enter the PACU (Post Anesthesia Care Unit). I understand and authorize the release of PHI as it relates to receiving post procedure consultation and instruction with me as I recover and exit the PACU.

Please print the full name and phone number of the responsible adult over 18 years who will transport you home and monitor you for 24 hours or length of time the provider recommends:

_____	_____
Name of responsible adult and relationship to patient	Phone # of designated responsible adult
_____	_____
Patient (printed legal name)	Signature