ALABAMA PAIN PHYSICIANS
Comprehensive Pain Care

2868 Acton Road
Birmingham, AL
35243

727 Memorial Drive
Bessemer, AL
35022

Welcome!

Thank you for choosing **Alabama Pain Physicians**.

We have compiled this New Patient Packet to provide you with expectations and relevant information regarding our office's policies and procedures. Please read through this packet to help yourself prepare for your upcoming appointment.

New Patient Appointment

All new patients arrive 30 minutes early for their first appointment. Please complete this entire new patient packet prior to arriving for your appointment for our staff to better serve you. If it is incomplete, you will be asked to complete it prior to your visit. If you prefer, you may fax the documents to 205.941.8829 or you may email it to newpatientpaperwork@cypresshc.com. It is recommended to bring the paper copy even if you submit it electronically.

It is a requirement for your appointment to bring your **insurance card(s)**, a valid state or government issued **ID**, and **copay** (if you have one). The ID can be a passport, driver's license, non-driver identification, or military ID.

Please also bring any imaging reports and medical records performed within the last two years.

Office Hours and Appointments

Our hours of operation are 8:00 a.m. – 5:00 p.m. Monday through Friday, excluding holidays. The lobby doors open at 7:30a.m. Please do not arrive prior to this time. Patients are seen in order of their scheduled appointments. We see patients by appointment only.

Please arrive promptly at your appointment for our staff to better serve the needs of every patient.

If you are more than 10 minutes late for your appointment, we reserve the right to reschedule your appointment to a later appointment that day, if available, or another day.

We understand patients may have a need to cancel or reschedule an appointment. We are happy to meet your scheduling needs, if possible. Please call at least 24 hours prior to your clinic appointment and 48 hours prior to a procedure if you need to cancel. This allows us to offer this time to another patient in need of an appointment. There are associated fees for not cancelling/rescheduling your appointment within the above-mentioned time frames.

Missed New Patient appt: $100 Missed Follow-up appt: $25 Missed Procedure appt: $100

Prescriptions

Prescriptions can only be refilled Monday through Friday between **9:00 AM** and **4:30 PM**. All prescription refill requests must be made on our medication line which can be reached at **(205) 332-3160**. These requests will be addressed in the order received. Allow, at minimum, 24 hours for prescriptions to be sent to the pharmacy. Prescription medications are never guaranteed on your first visit.

Financial Policy

Please read our financial policy that is enclosed with your New Patient Forms. For more information, contact our billing department at **(205) 332-3160** option **4**.

Medical Records

Copies of records or requests for transfer of records to other physicians must be done in writing. Please contact our medical records request line at **(205) 332-3160** or fax a signed release of information to 205.941.8829 . As a courtesy to our patients, we do not charge CURRENT patients or physician offices for medical records requests.

Former patients can request all their medical records at a $25 charge. This charge is applicable even if the patient requests that their records are sent to another physician's office.

Any other entity requesting medical records will be subject to costs at the following rate: $1 per page for the first 25 pages, $.50 for each subsequent page exceeding 25 pages, and a $5 search fee. These reasonable cost limitations were set forth by the Code of Alabama Title 12: Section 12-21-6.1. This charge is payable in advance when the forms are submitted to us for completion. Medical records request will be completed within 30 days of the request.

Medical Forms

There will be a $25 charge per form, and this charge is payable at the time forms are submitted to us for completion. FMLA and disability forms are completed on a case-by-case basis.

Please allow 10 business days are necessary to complete paperwork. Medical forms CANNOT be completed on the days you are seen by one of our physicians.

Patient Financial Agreement

Please understand that payment for services is an important part of the provider-patient relationship. In order to accommodate the needs of our patients, we have enrolled, and are contracted with many health plans. If you do not have insurance, proof of insurance, or participate in a plan that will not honor assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

Methods of Payment

We make payment as convenient as possible by accepting cash, MasterCard, Visa, Discover, and in-state checks. A $40.00 service fee will be charged for all returned checks. If two checks are returned for insufficient funds, we will no longer accept checks. Should you require a payment plan, please contact our billing department at **(205) 332-3160** option **4.**

Medical Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require government issued photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, and reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier we will not negotiate reduced fees with your carrier.

Patient Financial Agreement (continued)

Patient Co-Pay, Co-Insurance, and Deductible Policy

Due to the policy provisions in your contract with your insurance carrier we are obligated to collect all patient responsibility balances.

If your insurance policy has provisions such as deductibles, co-insurances, or co-payments please note that these are provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier.

If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier.

If a portion of your fees are applied to an annual out of pocket maximum, and we do not collect that fee, your out-of-pocket maximum has not been correctly calculated.

Additionally, for those Medicare patients that may have any medical services that are eligible under Medicare, we are legally obligated to collect the patient responsibility co-insurance, co-payment, or deductible under the terms of the anti-kickback laws.

We sincerely regret if any of these regulatory provisions cause you an inconvenience, but we must be bound by all provisions of insurance policy and federal law. If you have any issues or concerns with your insurance we will be more than happy to assist in the resolution of those issues or concerns. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

I have read and understand the above financial policy. I agree to assign insurance benefits to **Cypress Healthcare** whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Signature of Patient/Responsible Party

Date

Printed Name of Patient/Responsible Party

General Information Sheet

Name: _____ Date of Birth: _____

Gender: ☐ Male Female Social Security #: _____

Race: ☐ African American ☐ Asian ☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander ☐ Caucasian/White ☐ Other

Current Address: _____

_____

Height: _____ Weight: _____ lbs.

Phone Numbers (please check the primary contact number)

☐ Home: _____ ☐ Cell: _____ ☐ Other: _____

Email Address: _____

Emergency Contact: _____ Phone #: _____

Emergency Contact Relationship: _____

Referring Physician: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Other Physician(s):

i.e.-neurosurgeon, cardiologist, psychiatrist _____

_____

_____

Responsible Party Information (If different than patient information)

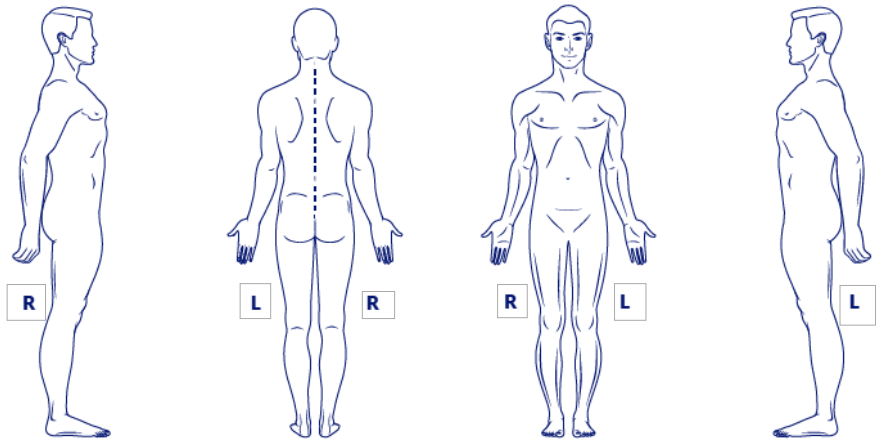
Relationship to Patient: _____ Date of Birth: _____

Name of responsible party: _____ Social Security #: _____

Initial Visit History

Name: _____ Age: _____ Date of Birth: _____

1. Please shade in the area of your pain in the image to the right.



2. What is your chief complaint/purpose of your visit today?

_____

3. Where is your problem located?

☐ Lower Back ☐ Neck ☐ Head ☐ Middle Back ☐ Other: _____

4. How long have you had this problem?

☐ Months _____ ☐ Years _____

5. Under what circumstances did the pain begin?

☐ Accident at work ☐ Accident at home ☐ Following Surgery
☐ Pain just began, no reason ☐ Motor vehicle accident
☐ Following illness ☐ Other: _____

6. How would you describe your pain?

☐ Aching ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Numb ☐ Burning ☐ Throbbing

7. On a scale of 1-10, on average how bad is your pain? _____ At worst? _____
(1=none, 10=worst) At Least? _____

8. When do your symptoms occur?

☐ Constantly ☐ With Activity ☐ At Rest ☐ Other: _____

Initial Visit History (continued)

Name: _____ Date of Birth: _____

9. Which statement best describes your pain?

☐ Always present, always the same intensity.
☐ Always present, intensity varies.
☐ Usually present, but have short periods without pain.
☐ Often present, but I am pain free for most of the day.

10. Do any of the following make your pain feel worse? (Check all that apply)

☐ Bending ☐ Sitting ☐ Twisting ☐ Standing ☐ Walking ☐ Lifting
☐ Coughing/Sneezing ☐ Sexual Activity ☐ Lying Flat ☐ Physical Activity
☐ Can't Find a Comfortable Position ☐ Other: _____

11. Do any of the following make your pain feel better? (Check all that apply)

☐ Relaxation ☐ Medicines ☐ Sitting ☐ Heat ☐ Standing
☐ Sexual Activity ☐ Lying Down ☐ Alcoholic Drinks ☐ Walking
☐ Nothing makes it feel better ☐ Other: _____

12. Do you have any associated symptoms? (Check all that apply)

☐ Numbness ☐ Tingling ☐ Weakness ☐ Headache ☐ Dizziness
☐ Nausea ☐ Vomiting ☐ Fatigue ☐ Balance Problems
☐ Bowel or Bladder Problems ☐ Other: _____

13. Please use the following scale to rate your ability to cope with your pain. (Circle the appropriate number)

Unable to cope 0 1 2 3 4 5 6 7 8 9 10 *Cope very well*

14. What treatments have you already had for this condition? (Check all that apply)

☐ Physical Therapy ☐ Chiropractor ☐ Ibuprofen/Aspirin ☐ Prescription Painkillers
☐ Oral Steroids ☐ Other: _____
☐ Pain Injections: _____
☐ Past Surgeries for this condition: _____

15. Does it radiate anywhere?

Leg: ☐ Left ☐ Right ☐ Both ☐ Above Knee ☐ Below Knee
Arm: ☐ Left ☐ Right ☐ Both ☐ Above Elbow ☐ Below Elbow

16. Have you previously been a patient at another pain clinic? ☐ Yes ☐ No

If "Yes", where? _____

17. Have you previously had any recent imaging (X-Ray, MRI, CT, etc.) taken? ☐ Yes ☐ No

Facility: _____ Phone #: _____
Type of Imaging: _____ Date of Exam: _____
Facility: _____ Phone #: _____
Type of Imaging: _____ Date of Exam: _____

Initial Visit History (continued)

Name: _____ Date of Birth: _____

18. Please list any medications you are currently taking as well as the dosage, frequency and duration:

_____

_____

_____

_____

_____

19. Please list previous pain medications tried:

_____

_____

_____

_____

_____

20. Are you pregnant? ○ Yes ○ No

21. Are you breastfeeding? ○ Yes ○ No

22. List any medication you are allergic to and your reaction to them:

Medication	Reaction

Are you allergic to seafood? ☐ Yes ☐ No

Are you allergic to contrast dye? ☐ Yes ☐ No

Are you allergic to betadine? ☐ Yes ☐ No

Are you allergic to iodine? ☐ Yes ☐ No

Past Medical History

Name: _____ Date of Birth: _____

Which of the following conditions has your Doctor diagnosed you with?:

Please check all that apply

Neurological:
- ☐ Multiple Sclerosis
- ☐ TIA
- ☐ Stroke
- ☐ Brain Injury
- ☐ Spinal Cord Injury
- ☐ Migraines
- ☐ Seizures

Hepatic:
- ☐ Liver Failure
- ☐ Gall Stones
- ☐ Jaundice

Endocrine:
- ☐ Cushing's disease
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Goiter
- ☐ Grave's Disease
- ☐ Liver Disease
- ☐ Thyroid Disease

Urinary & Reproductive:
- ☐ Endometriosis
- ☐ Enlarged Prostate
- ☐ Incontinence
- ☐ Fibroids
- ☐ Interstitial Cystitis
- ☐ STDs: _____

Vascular:
- ☐ Coronary Artery Disease
- ☐ Arteriosclerosis
- ☐ Peripheral Vascular Disease
- ☐ High Blood Pressure
- ☐ Aneurism
- ☐ Hypertension

Musculoskeletal:
- ☐ Rotator Cuff Injury
- ☐ Joint Replacements

Heart:
- ☐ Atrial Septal Defect
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Arrhythmia
- ☐ PFO Closure
- ☐ Irregular Heart Beat
- ☐ Mitral Valve Prolapse
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation
- ☐ Pacemaker

Rheumatology:
- ☐ Arthritis (type unknown)
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Gout
- ☐ Lupus or "SLE"
- ☐ Ankylosing Spondylitis
- ☐ Childhood Arthritis
- ☐ Osteoporosis
- ☐ Polymyalgia Rheumatic (PMR)
- ☐ Other: _____

Respiratory:
- ☐ Pleurisy
- ☐ Respiratory Distress Syndrome
- ☐ Emphysema
- ☐ COPD
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pulmonary Hypertension
- ☐ Tuberculosis

Renal:
- ☐ Nephritis
- ☐ Kidney Failure
- ☐ Kidney Stones

Gastrointestinal:
- ☐ Ulcers: _____
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Diverticulosis
- ☐ Diverticulitis
- ☐ Irritable Bowel Syndrome
- ☐ Esophageal Varices
- ☐ GERD
- ☐ Pancreatitis
- ☐ Peptic Ulcers
- ☐ Barrett's Esophagus

Heme/Oncology:
- ☐ Cancer:
  _____
  _____
- ☐ Clotting Disorders:
  _____
  _____
- ☐ Bleeding Disorders:
  _____
  _____
- ☐ Myositis
- ☐ Addison's Disease
- ☐ Peripheral Neuropathy

Infectious Disease:
- ☐ Chicken Pox
- ☐ Mumps
- ☐ Hepatitis
- ☐ Parasites
- ☐ Measles
- ☐ Malaria
- ☐ Typhoid Fever
- ☐ Infectious Mononucleosis(mono)
- ☐ Traveler's Diarrhea
- ☐ Other: _____

Psychiatric:
- ☐ Depression
- ☐ Anxiety
- ☐ Borderline Personality Disorder
- ☐ Schizophrenia
- ☐ Other: _____

Other: _____
- ☐ None To Report

Have you ever had psychological or psychiatric treatment? ☐ Yes ☐ No

Have you ever been physically or sexually abused? ☐ Yes ☐ No

Family & Social History

Name: _____ Date of Birth: _____

1. Does your family have a history of significant medical problems?

	Relationship to you
☐ Diabetes	_____
☐ Hypertension	_____
☐ Heart Disease	_____
☐ Stroke	_____
☐ Cancer	_____
☐ Other (Please Specify)	_____

2. Marital Status:

☐ Married ☐ Never Married ☐ Divorced ☐ Widowed

3. Do you live:

☐ Alone ☐ With Spouse ☐ With Children ☐ With Relatives ☐ With Friend/Roommates

4. If you are married or have a spouse equivalent, please use the following rating scales to describe your relationship with your spouse by circling the correct number:

Relationship before pain began:

Poor 1 2 3 4 5 6 7 8 9 10 *Excellent*

Relationship Now:

Poor 1 2 3 4 5 6 7 8 9 10 *Excellent*

5. What is the highest level of education you have completed?

☐ Some High School ☐ High School Diploma/GED ☐ Some College ☐ Associates Degree
☐ Bachelor's Degree ☐ Graduate/Professional Degree ☐ Technical Degree

6. Do you drink Alcohol?

☐ No ☐ Yes, how much? _____

7. Do you have any prior history of drug abuse?

☐ No ☐ Yes, how much? _____

8. What is your smoking status?

☐ Never ☐ Former, how much? _____
☐ Current, how much? _____

Work & Medical History

Name: _____ Date of Birth: _____

1. What is your occupation?

☐ Unemployed ☐ Student ☐ Laborer ☐ Managerial ☐ Professional
☐ Other: _____

2. Do you work?

☐ Full-time ☐ Part-time ☐ Self-employed
☐ Unemployed. Last date worked: _____

3. Did you stop working because of your pain? ☐ No ☐ Yes

4. Have you received financial compensation related to your pain? ☐ No ☐ Yes

5. Are you now bringing a lawsuit because of your pain? ☐ No ☐ Yes

6. Have you already filed suit for compensation? ☐ No ☐ Yes

7. Is this visit related to worker's compensation? ☐ No ☐ Yes

A. If so, what was your initial date of injury? _____

B. What is the location of your injury? _____

C. What is the name and contact information of your case adjuster?

Name: _____

Phone Number: _____

8. Have you previously had any type of surgery? ☐ No ☐ Yes

If so please list the type of surgery and the year it was performed:

_____

_____

_____

_____

_____

What Medical Signs or Symptoms Do You Currently Have?

Name: _____ Date of Birth: _____

Please check all that apply

Constitutional Symptoms :
- ☐ No Symptoms
- ☐ Chills
- ☐ Fever
- ☐ Loss of Appetite
- ☐ Poor Sleep/Insomnia
- ☐ Night Sweats
- ☐ Recent Weight Loss
- ☐ Recent Weight Gain

Eyes:
- ☐ Normal
- ☐ Eye Pain (Circle one) ☐ Left, ☐ Right ☐ Both?
- ☐ Vision Loss

Ears, Nose and Throat:
- ☐ Normal

Ears:
- ☐ Decreased Hearing
- ☐ Earache: ☐ R ☐ L

Nose and Sinuses:
- ☐ Nasal Congestion
- ☐ Sinus Trouble

Mouth & Throat:
- ☐ Difficulty Swallowing
- ☐ Hoarseness

Cardiovascular:
- ☐ Normal
- ☐ Chest Discomfort
- ☐ Chest Pain
- ☐ Fainting
- ☐ High Blood Pressure
- ☐ Leg Cramps at Rest
- ☐ Leg Cramps on Exertion
- ☐ Leg Swelling

Pulmonary:
- ☐ Normal
- ☐ Cough
- ☐ Asthma
- ☐ Pain With Breathing

Gastrointestinal:
- ☐ Normal
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hepatitis
- ☐ Peptic Ulcers
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting

Genitourinary:
- ☐ Normal
- ☐ Frequency
- ☐ Incontinence
- ☐ Urgency

Musculoskeletal:
- ☐ Normal

Neck:
- ☐ Pain
- ☐ Stiffness

Back:
- ☐ Pain
- ☐ Stiffness Tenderness

Joints:
- ☐ Aching
- ☐ Arthritis
- ☐ Limitation of Joint Movement
- ☐ Redness
- ☐ Morning Stiffness
- ☐ Swelling
- ☐ Tenderness

Muscles:
- ☐ Aches
- ☐ Weakness

Skin, Hair, Nails:
- ☐ Normal

Hair:
- ☐ Falling Out
- ☐ Itching and Scaling of the Skin
- ☐ Localized Hair Loss

Nails:
- ☐ Discoloration
- ☐ Excessively Dry or Brittle Nails

Skin:
- ☐ Change in Skin Pigmentation/Color
- ☐ Easy Bruising
- ☐ Rash

Neurological:
- ☐ Normal
- ☐ Blackouts
- ☐ Change in Behavior
- ☐ Disorientation
- ☐ Headaches
- ☐ Involuntary Movements
- ☐ Numbness
- ☐ Paralysis
- ☐ Seizures
- ☐ Speech
- ☐ Tingling
- ☐ Tremors
- ☐ Unsteadiness/Dizziness
- ☐ Weakness

Psychiatric
- ☐ Normal

Mood
- ☐ Anxiety
- ☐ Depression
- ☐ Mood Swings
- ☐ Nervousness
- ☐ Stressed

Mental State
- ☐ Hallucinations
- ☐ Paranoid
- ☐ Memory Loss
- ☐ Suicidal Ideation

Endocrine:
- ☐ Normal
- ☐ Cold Intolerance
- ☐ Excessive Sweating
- ☐ Excessive Thirst
- ☐ Heat Intolerance
- ☐ Hot flashes

Hematologic/Lymphatic:
- ☐ Normal

Hematologic
- ☐ Bruises Easily
- ☐ Bleeding
- ☐ History of Anemia
- ☐ History of Transfusion Reactions

Lymphatic
- ☐ Enlarged Lymph Nodes

Immunologic:
- ☐ Normal
- ☐ HIV
- ☐ Persistent Infections

ALABAMA PAIN PHYSICIANS
Comprehensive Pain Care

2026 HIPAA Privacy Authorization Form

Cypress Healthcare includes all of the following entities and their respective facilities: Alabama Pain Physicians, Renew Clinic, and National Pain Custom Pharmacy.

Authorization for use or disclosure of protected health information.

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

Patient Name: _____ Date of Birth: _____

Please list names and relationships of all persons that you authorize *Alabama Pain Physicians* to release your medical information to during the course of your care:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I hereby authorize all medical sources to release and disclose the following protected health information to:

Alabama Pain Physicians
2868 Acton Road, Birmingham, Alabama 35243
Phone: 205-332-3160 | Fax: 205.941.8829

Specific information to be disclosed:

- ☐ **Entire Medical Record**
- ☐ **Entire Medical excluding Mental Health Record**
  **include all documents related to the Renew Clinic*
- ☐ **Only information related to (specify):**
  _____
- ☐ **Only the period of events from** _____ **to** _____
- ☐ **Other (please describe):**
  _____

The information for which I'm authorizing disclosure will be used for the following purpose:

- ☐ **Further Medical Care**
- ☐ **My Personal Use**
- ☐ **Other (please describe)**
  _____

Important Information About Your Rights

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, drug testing and screening or any such related information. I understand that the health information released may be subject to re-disclosure by Alabama Pain Physicians and no longer protected by the Federal Privacy Rules.

By signing this form, I am consenting to the use and disclosure of my protected health information to carry out treatment, payment, health care operations, or other purposes as I may direct or as permitted by law to the above individuals.

I have the right to request that Alabama Pain Physicians restrict how it uses or discloses my protected health information to carry out treatment, payment, and health care operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I understand that this authorization is voluntary and I may refuse to sign this authorization. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I may revoke this authorization, in writing, at any time by sending a written request to Alabama Pain Physicians. The revocation must be signed and dated, and mailed to the compliance officer at 2868 Acton Road, Birmingham, Alabama 35243. The revocation will not have any effect on any uses or disclosures prior to the receipt of the revocation. This authorization will expire one calendar year from the date signed unless otherwise specified.

_____ _____
Signature of Patient/Patient Representative Date

_____ _____
Printed Name of Patient/Patient Representative Relationship to Patient

_____ (Initial) I acknowledge that I have been provided a copy of Alabama Pain Physicians' Notice of Privacy Practices explaining my rights and permitted uses and disclosures with regard to my protected health information.

Consent to Treat/Authorization to Release Information to Insurance Providers for Payers

I am consenting to treatment at Cypress Healthcare. I hereby authorize Cypress Healthcare, or its agents to furnish information to Medicare, insurance carriers, or other third party payers concerning my illness, and treatment. I hereby assign to the physicians all payments for medical services to myself or to my dependents.

I understand that I am responsible for the cost of the medical services rendered and agree to pay any, and all amounts not paid by others within thirty (30) days from the date billed unless I made previous arrangements with my insurance company. I further agree to pay all collection costs including but not limited to court costs, and reasonable attorney's fees, if it becomes necessary to turn this account over to an outside party for collection.

This authorization and release is in effect until I choose to revoke it.

Patient/Responsible Party: _____ Date _____

Medigap Authorization (For Medicare Patients Only)

A Medigap or Medicare supplement policy is a health insurance policy or another health benefit plan offered by a private company to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. I authorize Cypress Healthcare and its employees to release to my *Secondary Insurance Policy Provider* any information needed to determine these benefits payable for related services. I request that payment of authorized Medigap due to me on my behalf be made payable to Cypress Healthcare for these services furnished me by that participating physician or supplier. This authorization is in effect until I choose to revoke it.

Patient Signature _____ Date _____

ALABAMA PAIN PHYSICIANS
Comprehensive Pain Care

2026 Pain Management Medication Agreement

Opiate medications are prescribed for many of our patients. These medications have the potential for misuse, abuse and addiction and are therefore closely monitored by local, state and federal authorities.

Side effects of opioids may include but are not limited to sedation, respiratory depression, decreased sex drive, lower extremity swelling, dental decay, hives, itching, slurred speech, impaired thinking and function, ICU admission, coma and death. For these reasons, we reserve the right to change to a non-opioid regimen at any time.

In the event of potentially life threatening emergencies such as severe respiratory depression and over-sedation, you should call 911. Our physicians may be contacted 24 hours a day by calling the designated number for emergent issues only. Calls made for non-emergent issues or issues which should be handled during office hours may jeopardize continued treatment in our practice.

I agree to accept the following responsibilities regarding controlled substances while I am a Cypress Healthcare patient.

1. I agree to not ask multiple physicians nor accept prescriptions for controlled substances without approval from Cypress Healthcare provider.
2. **ALL** pain management interventional procedures must be performed at Alabama Pain Physicians. Receiving procedures elsewhere will be subject to dismissal.
3. No prescriptions will be refilled early.
4. Lost or stolen prescriptions will not be replaced.
5. No prescriptions will be refilled if I lose or destroy any of my medication.
6. I will get all of my prescriptions filled at one pharmacy which is:

   _____

   If the above pharmacy does not have the prescription, then we expect patients to go to another pharmacy rather than receive a partial refill on the opioid. We will not write additional prescriptions to cover the balance of a shortfall from a pharmacy with insufficient supplies. Therefore in advance, ask the pharmacist not to fill the script with a partial refill if the pharmacy lacks sufficient stocks to carry out the prescription filling. If a second pharmacy must be used to fill a script of opioids, then notify our practice at that time regarding the situation.
7. I will not alter or forge any prescriptions.
8. I will only take medication as prescribed and will exercise self-control when taking any type of controlled substances.
9. Controlled substances will only be refilled during a clinic visit. Other refills will only be authorized during normal clinic hours on Monday through Friday from 9:00 am-4:30pm. Refills will NOT be made on weekends, holidays or after office hours. Repeated interruptive calls and voice messages on the medication line are grounds for dismissal.
10. Drug testing will be required to monitor compliance with the prescribed treatment. Drug testing may not always be covered by your insurance carrier. If this is the case, you will be required to pay the cash price. Failure to do so may result in your opiates being discontinued.
11. Pill counts will be performed periodically to determine compliance with the medication treatment. Refusal to comply with this monitoring may result in immediate termination of pain medications or dismissal from the clinic.
12. Any illegal (street) drug use may result in immediate termination.
13. Many different treatment options exist for chronic pain. If opiate medications are a possible treatment, I must follow the Cypress Healthcare protocol before any opiate medications are prescribed.

I understand and agree to follow these patient rules for pain management while under the care of Cypress Healthcare. The staff of Cypress Healthcare has answered any and all of my questions in order to understand the above. If I do not follow these rules in their entirety, the clinic physicians and staff reserve the right to refuse treatment through medication.

_____ _____
Patient Signature Date

_____ _____
Patient Name (Printed) Date of Birth

ALABAMA PAIN PHYSICIANS
Comprehensive Pain Care

2026 Pain Management Medication Agreement *(continued)*

I recognize that the following are reasons opioids may be immediately discontinued, modified or reduced (including but not limited to):

- Multiple no shows, cancellations, or late appointments
- Taking old opioid prescriptions
- Non-compliance with other forms of treatment. (I.e. procedures, non-opioids, therapy, etc.)
- Hoarding (stockpiling medication)
- Multiple calls to the clinic about pain or medications
- Accepting a prescription for cough syrup with hydrocodone or codeine without calling and informing us
- Early requests for medications due to running out
- Lost or stolen prescription
- Non-emergent calls regarding opioids on nights or weekends
- Telephone report that patient is selling drugs
- Family report that patient is impaired
- ER visit for chronic pain complaint
- Showing up negative for prescribed medications on urine drug screen
- Taking a family member or friends medication
- Failing to show up for a pill count or drug screen
- Not bringing medication to pill count and drug screen
- Being inappropriate on pill count
- Marijuana in drug screen
- Appearing intoxicated at clinic visits
- One time episode of multiple prescribers of narcotics with reason but did not inform us
- Abusive behavior to staff
- Overtaking medication
- Evidence of buying medication off the street
- Attempted suicide
- Attempted alteration of urine sample
- Drug or Alcohol related arrest
- Altering or forging prescriptions
- Police reports patient is selling drugs
- Overdose resulting in hospital admission
- Illicit drugs present in urine (Cocaine, methamphetamines, heroin, etc.)
- Refusal to take drug screen in allotted timeframe
- Obtaining narcotics from multiple prescribers
- Hostile or threatening behavior in order to obtain narcotics
- Injection of oral or transdermal narcotics

Patient Signature _____ Date _____

Patient Name (Printed) _____ Date of Birth _____

ALABAMA PAIN PHYSICIANS
Comprehensive Pain Care

2026 Extended Release/Long-Acting Medication Agreement

Extended-release and long-acting (ER/LA) pain medications can be more dangerous than short-acting drugs. These medications are very closely monitored by the local, state and federal authorities. For more information on this type of drug, visit *dailymed.nlm.nih.gov.*

If I am ever prescribed ER/LA medications, I agree to:

1. Read the Medication Guide provided by the pharmacy when I fill a prescription.
2. Take the medicine exactly as it is prescribed.
3. Store the medication away from children in a safe place.
4. Contact my doctor about how to dispose of my medication.
5. Talk to my pain management doctor before stopping this medication.
6. Call 911 or the local emergency service if
    a. I take too much medicine.
    b. I have trouble breathing or have shortness of breath.
    c. A child has taken this medicine.
7. Talk to my pain management doctor
    a. If the dose I am taking does not control my pain.
    b. If I start experiencing any side effects.
    c. About all of the medicines I take, including over-the counter medications, vitamins and dietary supplements.
8. Never give my medicine to others.
9. Never take medicine unless it was prescribed for me.
10. Never break, chew, crush, dissolve or inject my medication. If I am unable to swallow my medicine whole, I will talk to my doctor.
11. Never drink alcohol while taking this medication.
12. Bring a current list of medications I take to every clinic visit. This list should include over-the counter medications, vitamins and dietary supplements.

I understand the possible risks and benefits of taking an ER/LA medicine and agree to follow these rules for taking extended release and long-acting medications while under the care of *Cypress Healthcare*. A member of the *Cypress Healthcare* staff has answered any and all of my questions about the agreement outlined above. If I do not follow all of these rules, the clinic's physicians and staff reserve the right to refuse treatment through medication and may be grounds for dismissal.

_____
Signature of Patient

_____
Signature of Cypress Healthcare Staff

_____
Printed Name of Patient

Date: _____ / _____ / _____

ALABAMA PAIN PHYSICIANS
Comprehensive Pain Care

Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP®-R)

Name: _____ Date of Birth: _____

	The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
1	How often do you have mood swings?	○	○	○	○	○
2	How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3	How often have you felt impatient with your doctors?	○	○	○	○	○
4	How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5	How often is there tension in the home?	○	○	○	○	○
6	How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7	How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8	How often do you feel bored?	○	○	○	○	○
9	How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10	How often have you worried about being left alone?	○	○	○	○	○
11	How often have you felt a craving for medication?	○	○	○	○	○
12	How often have others expressed concern over your use of medication?	○	○	○	○	○
13	How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○

Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP®-R) *cont.*

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.		Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
14	How often have others told you that you had a bad temper?	☐	○	○	○	○
15	How often have you felt consumed by the need to get pain medication?	☐	○	○	○	○
16	How often have you run out of pain medication early?	☐	○	○	○	○
17	How often have others kept you from getting what you deserve?	☐	○	○	○	○
18	How often, in your lifetime, have you had legal problems or been arrested?	☐	○	○	○	○
19	How often have you attended an AA or NA meeting?	☐	○	○	○	○
20	How often have you been in an argument that was so out of control that someone got hurt?	☐	○	○	○	○
21	How often have you been sexually abused?	☐	○	○	○	○
22	How often have others suggested that you have a drug or alcohol problem?	☐	○	○	○	○
23	How often have you had to borrow pain medications from your family or friends?	☐	○	○	○	○
24	How often have you been treated for an alcohol or drug problem?	☐	○	○	○	○

Please include any additional information you wish about the above answers. Thank you.

Name: _____ Date of Birth: _____ Date: _____

Revised Oswetry Disability Index

Please answer every section and mark in each section only the ONE box which most applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them

Section 2 – Personal Care (Washing, Dressing, etc.)

- ☐ 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 manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I 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 extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than 30 minutes.
- ☐ Pain prevents me from sitting for 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 extra pain.
- ☐ Pain prevents me from standing 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

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – 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. dancing.
- ☐ 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 9 – Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

CYPRESS HEALTHCARE

NOTICE OF PRIVACY POLICY

Effective January 2026

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

The following is the privacy policy ("Privacy Policy") of **Cypress Healthcare, LLC** ("Covered Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. **Cypress Healthcare** includes all of the following entities and their respective facilities: **Alabama Pain Physicians, National Pain Custom Pharmacy, and Renew Clinic.** All of these entities follow the terms of this notice. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information. We are required to notify you of any breach of your unsecured protected health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: **(A)** the provision, coordination, or management of health care and related services by health care providers; **(B)** consultation between health care providers relating to a patient; or **(C)** the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: **(A)** billing and collection activities and related data processing; **(B)** actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; **(C)** medical necessity and appropriateness of care reviews, utilization review activities; and **(D)** disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include: **(A)** development of clinical guidelines; **(B)** contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; **(C)** reviewing the qualifications of and training health care professionals; **(D)** underwriting and premium rating; **(E)** medical review, legal services, and auditing functions; and **(F)** general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. Examples of instances in which we are required to disclose your personal health information include: **(A)** public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; **(B)** disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; **(C)** health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; **(D)** judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; **(E)** law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; **(F)** disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; **(G)** for research purposes under certain

As Required By Law *(continued)*

conditions; **(H)** to avert a serious threat to health or safety; **(I)** military and veterans activities; **(J)** national security and intelligence activities, protective services of the President and others; **(K)** medical suitability determinations by entities that are components of the Department of State; **(L)** correctional institutions and other law enforcement custodial situations; **(M)** covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. The following uses and disclosures will be made only with your authorization: **(A)** most uses and disclosures of psychotherapy notes (if recorded by a covered entity); **(B)** uses and disclosures of protected health information for marketing purposes, including subsidized treatment communications; **(C)** disclosures that constitute a sale of protected health information; and **(D)** other uses and disclosures not described Privacy Policy. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you to raise funds for Covered Entity, however, you will have the right to opt out of such fundraising communications with each solicitation. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. You may request restrictions on the following uses or disclosures: **(A)** to carry out treatment, payment, or healthcare operations; **(B)** disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; **(C)** instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; **(D)** permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or **(E)** disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law. If you have paid for services out-of-pocket, in full, you may request that we not disclose your protected health information related solely to those services to a health plan. Such request must be made in writing, and the request should include: **(A)** the information to be restricted; **(B)** the type of restriction being requested (i.e. on the use of information, the disclosure of information, or both); and **(C)** to whom the limits should apply. If such request is made, we must accommodate your request, except where we are required by law to make a disclosure. All requests for restrictions shall be sent to **Cypress Healthcare, LLC, 2868 Acton Road, Birmingham, Alabama 35243.**

Right To Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

Right To Inspect And Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, except for **(A)** psychotherapy notes, **(B)** information complied in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and **(C)** health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the

right to deny your request for amendment, if: **(A)** we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, **(B)** the information is not part of your designated record set maintained by us, **(C)** the information is prohibited from inspection by law, or **(D)** the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to **Cypress Healthcare, LLC, 2868 Acton Road, Birmingham, Alabama 35243.**

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. We are not required to provide accountings of disclosures for the following purposes: **(A)** treatment, payment, and healthcare operations, **(B)** disclosures pursuant to your authorization, **(C)** disclosures to you, **(D)** for a facility directory or to persons involved in your care, **(E)** for national security or intelligence purposes, **(F)** to correctional institutions, and **(G)** with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to **Cypress Healthcare, LLC, 2868 Acton Road, Birmingham, Alabama 35243.**

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our Privacy Officer at **205-332-3160** or **privacyofficer@cypresshc.com.** A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to **Cypress Healthcare, LLC** or at the following email address: **privacyofficer@cypresshc.com.** You have the right to obtain a paper copy of this Privacy Policy from us upon your written request, even if you have agreed to receive the Privacy Policy electronically. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our Privacy Officer at the address, telephone number, or e-mail address listed above.

ALABAMA PAIN PHYSICIANS
Comprehensive Pain Care

Cypress Healthcare Patient Portal

Powered by ModMed

Use the Cypress Healthcare ModMed Patient Portal to review and update your information before your appointment and to stay connected with our office.

1 Open the patient portal

Go directly to cypress.modmedapp.com on your phone, tablet, or computer.

2 Sign in or activate your account

Use the portal access information provided by our office. If you have not activated your account or have trouble signing in, contact our office for assistance.

3 Review your information

Before your visit, review and update any information the portal asks you to confirm, including contact information, medical history, medications, allergies, pharmacy information, and other available intake items.

4 Use the portal between visits

Depending on the features enabled for your account, the portal may let you view appointments and health information, send secure messages, request refills, view results or notes, and access other online services.

cypress.modmedapp.com

ALABAMA PAIN PHYSICIANS
Comprehensive Pain Care

Before Your First Appointment

Completing your information before you arrive helps our staff prepare for your visit and can reduce check-in time.

Patient Portal Checklist

- [ ] Go to cypress.modmedapp.com and sign in.
- [ ] Review your name, address, phone number, email address, and other contact information.
- [ ] Review your medical history, medications, allergies, and preferred pharmacy when those items are available in the portal.
- [ ] Complete any questionnaires, consents, or forms assigned to you in the portal.
- [ ] Bring your insurance card(s), a valid government-issued photo ID, and your copay if applicable.
- [ ] Bring any recent imaging reports or medical records requested by our office.

Need help with the portal?

If you cannot access your account, did not receive portal access information, or are unsure what needs to be completed, contact Alabama Pain Physicians at 205.332.3160.

For your privacy, do not send sensitive medical information through ordinary email when the secure patient portal is available.

Patient Portal: cypress.modmedapp.com