Knoxville Office
2606 Greenway Dr, Ste 101
640 North Building
Knoxville, TN 37918

Alcoa Office
186 Airport Plaza Blvd.
Ste E
Alcoa, TN 37701

Office: 865-687-3313 Fax: 865-687-3362

Enclosed you will find the documents needed for your scheduled appointment on _____ with your arrival time at _____

Please fill out and bring all of these documents, your valid TN ID or TN Driver's License, Insurance cards and co-pay.

You will be required to provide a urine sample for a drug screen at this time, please be prepared to do so.

PLEASE DO NOT SIGN this paperwork until you come into the office, so that we can date and witness your signature.

Thank you, and we look forward to meeting you!

DIRECTIONS

Knoxville Office

2606 Greenway Dr., Ste. 101
Knoxville, TN 37918

Scan for Map / Directions

I-640 Going East

Use the 2nd from the right lane to take exit 6 for Old Broadway toward US-441/Broadway

Use the left 2 lanes to turn left onto Old Broadway

Turn right onto Greenway Dr

APMC is the 640 North building on the right.

I-640 Going West

Take exit 6 for US-441 toward Broadway

Turn left onto US-441 S/N Broadway

Turn right onto Mineral Springs Ave NE/Old Broadway

Continue on Old Broadway

Turn right onto Greenway Dr

APMC is the 640 North Building on the right.

Alcoa Office

186 Airport Plaza Blvd, Ste. E
Alcoa, TN 37701

Scan for Map / Directions

Alcoa Highway (US 129) Going South

Across from the Airport, turn left onto Airport Plaza Blvd. (Between McDonalds and Wendy's)

Continue on Airport Plaza Blvd.

Turn right into the lower level parking lot of the McGee Tyson Plaza (Brick building on the right).

Alcoa Highway (US 129) Going North

Across from the Airport, turn right onto Airport Plaza Blvd. (Between McDonalds and Wendy's)

Continue on Airport Plaza Blvd.

Turn right into the lower level parking lot of the McGee Tyson Plaza (Brick building on the right).

APMC - PATIENT INFORMATION SHEET

Patient First Name	Middle Name	Last Name	
Street Address	City	State	Zip Code
Social Security #	Birthday	Sex	Race / Ethnicity
Home Phone #	Mobile Phone #	Work Phone #	
Employer's Name and Address			
Email Address (optional)		Marital Status	
Pharmacy of Choice		Pharmacy Phone #	
Referring Physician			

Do you have a durable power of attorney for healthcare? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No

If yes, Please provide a copy of the above document(s) to the office for your medical record

PERSON / GUARANTOR RESPONSIBLE FOR PAYMENT OF SERVICES (IF DIFFERENT FROM PATIENT)		
First Name	Middle Name	Last Name
Street Address	City	State, Zip Code
Social Security #	Birthday	Sex
Home Phone #	Mobile Phone #	Work Phone #
Employer's Name and Address		

EMERGENCY CONTACT (MUST HAVE WORKING PHONE # THAT IS DIFFERENT FROM PATIENT)		
Name	Emergency Phone #	Relationship to patient

The Patient or Guarantor is responsible for payment in full of all services rendered by the physician or employees of APMC Inc. Payment in full is expected at the time of service unless arrangements are made in advance.

AUTHORIZATION, ASSIGNMENT, AND RESPONSIBILITY OF ACCOUNT

I hereby authorize APMC Inc. to release to my insurance companies &/or carriers any medical or other information needed for claims reimbursement. I hereby assign, transfer and set over to APMC Inc. all of my rights, title, and interest to medical reimbursement benefits under my Insurance policy with my documented insurance companies. I hereby acknowledge and accept responsibility for payment in full of all services rendered to me by APMC Inc.

_____ _____

Date Signature of Patient / Guardian

APMC - PATIENT MEDICAL HISTORY

Name:_____Date of Birth:_____Date:_____

Medical History:

_____
_____
_____
_____

Drug Allergies (list the allergic reaction to the medication, please):

_____
_____

List ALL medications AND doses you are currently prescribed:

_____
_____
_____
_____

Past Surgical History:

_____
_____

If you are a female between 18-55, do you use birth control, have you had a Bilateral Tubal Ligation, or are you post menopausal?_____

Social History (please circle the correct answer):
Do you smoke? Yes No How many cigarettes do you smoke a day?_____
Do you use alcohol? Yes No How many drinks do you consume week ?_____
How many caffeine products do you consume in a day?____ Hours of sleep per night?_____

Alternative Therapy (please list PT, Acupuncture, Heat/Ice, Massage Therapy and the dates):

_____
_____
_____

Previously tried NSAID:_____
Previously tried Narcotics:_____
Previously tried Tricyclic Antidepressants such as: Elavil/Amitriptyline, Doxepin, Pamelor/Nortriptyline, Tofranil, or _____
Previously tried Topical Creams: _____

Family History (please circle the answer):

Father: Deceased or Living History of: Cancer, Diabetes, Stroke, Heart Disease, High Blood Pressure other_____

Mother: Deceased or Living History of: Cancer ,Diabetes, Stroke, Heart Disease, High Blood Pressure other_____

General Rules for APMC, Inc Patients

- You must bring ALL medications prescribed by APMC to every routine appointment.
- You must ensure that we have an up to date telephone number and address in order to reach you at all times. You must have a voicemail set up so we can leave you a message. Please save our office phone number (865-687-3313) in your phone so it doesn't appear as spam. If not being able to reach you becomes a routine, you could be subject for dismissal.
- You must have a contract with only one pharmacy that you will use consistently to fill all schedule II drugs prescribed by the providers in this clinic.
- You understand that you may not receive the same controlled substance or one with similar therapeutic use from more than one provider within the same 30 day period. It is your responsibility to keep the provider informed of all the medication you take.
- Never give your medication to someone else for any reason.Never take drugs prescribed to someone else. Only take medication prescribed by your healthcare provider.You must take your medications as prescribed by your provider. You may not take additional doses or alter the prescriptions in anyway.
- Lock your medications in a secure place to keep them out of other people's hands. This is your responsibility. If your medications are lost or stolen, they will not be replaced. This is state law.
- You understand that for patient's and staff safety, APMC has cameras that record video and audio, placed appropriately around the clinic.
- If going to the hospital ER for admission you MUST leave your prescribed medications locked up at home. DO NOT TAKE YOUR MEDICATIONS TO THE HOSPITAL WITH YOU!
- We are required to monitor your drug use through the Tennessee Controlled Substance Monitoring program. Obtaining pain or anxiety medications from other doctors/providers in the same 30 day period is considered "Doctor Shopping." If you are caught Doctor Shopping you will be dismissed from this practice and reported to DEA.
- If you have a documented accident or injury or a planned procedure requiring additional medications, do not take your medications ahead of scheduled. You may call us to consult for any possible increases or changed in your medications. You may accept mediations given to you while you are in the hospital or emergency room. Once you leave, all medications must be prescribed by providers at APMC, Inc.
- Do not take your medications with alcohol.Do not combine sedatives or anti-anxiety drugs with medications unless approved by your provider. NO SUBOXONE, XANAX (ALPRAZOLAM), or SOMA (CARISOPRODOL)
- Do not suddenly stop taking a prescribed medication unless instructed to do so by an APMC healthcare provider.
- Your provider will write you 30 day prescriptions. You will not be authorized to come in to the office early or fill your prescriptions early.
- It is your responsibility to let us know if you will be going out of town and leave us with a contact number. Your turn may come for a random pill count and drug screen and MUST be able to reach you by phone. Remember to let us know before you leave town.
- All copays, deductibles, and non-covered charges will be collected at the time of your office visit. If you are a self-pay patient, you must be prepared to pay at the time of your visit. We accept checks, VISA, and MasterCard for your convenience. If you are not prepared to pay at the time of your visit, we will need to reschedule your appointment. If a check is returned, you will be charged a nsf fee and this will need to be paid in addition to the amount of the check before your next office visit is scheduled.
- You understand that you are subject to random pill counts. You could be called at any time to present yourself and your medications at the office within a certain amount of time. Failure to appear for a random pill count will result in immediate dismissal from this practice and no further treatment will be provided. Failure to present the correct number of medication will also result in immediate dismissal from this practice. If you are out of town, a local pharmacy can perform the pill count.
- Please refrain from smoking or wearing perfume prior to coming to the practice. The practice doesn't want to be unwelcoming, but several providers are allergic or extremely sensitive to the odors. If the odor is excessive, then you will be rescheduled

Patient Signature:_____ Date:_____

Staff Signatue:_____ Date:_____

APMC - MEDICATION MANAGEMENT AGREEMENT

PATIENT NAME: _____ PATIENT DOB: _____

PHYSICIAN: Phillip J. Haggerty, M.D. NPI# 1902820954 X_____

I CERTIFY THAT I will use my pharmacy, _____ (pharmacy name, number and zip code), as my only pharmacy for controlled substances prescribed to me by Dr. Haggerty and understand that using another pharmacy without express permission from him may lead to being dismissed as a patient.

I UNDERSTAND the following:

- Only my pain management provider will prescribe controlled substance medications for me.
- I agree not to ask for controlled substance medications from any other healthcare provider without documented prior knowledge and written consent from Dr. Haggerty.
- I agree to keep all scheduled appointments with Dr. Haggerty and all recommended diagnostics tests or appointments with other specialists, therapists, and psychological counselors. I understand three missed appointments or same day cancellations will lead to being discharged as a patient.
- I agree to provide regular samples for urine, hair and/or serum drug screens as requested. Positive tests for any controlled or illegal substances not prescribed by Dr. Haggerty will result in my dismissal due to clinical noncompliance.
- I will immediately respond to all requests for pill counts. I understand it is my responsibility to keep Dr. Haggerty's office up to date with my phone numbers and contact information.
- No prescriptions will be refilled early without documented need and written consent.
- I agree to take my medication as prescribed and not to take at a greater rate than prescribed.
- No prescriptions will be replaced if I lose, destroy or have any of my medication stolen.
- No Soma, Xanax or Suboxone shall be dispensed to me from any provider.
- I understand emergencies can occur and under some circumstances exceptions to these guidelines may be appropriate IF Dr. Haggerty's office is notified as soon as possible during regular business hours. Emergencies will be considered on an individual basis.

<u>Special Considerations for Women of Child Bearing Age with Reproductive Capacity: (As Required by TN Dept. of Health Guidelines)</u>

- Assessment of pregnancy status prior to starting therapy
- Assessment of pregnancy status at each visit
- Prescriber shall recommend a reliable form of contraception
- Education shall be provided regarding risk of therapy to patient and unborn child
- If Patient becomes pregnant, she will immediately notify prescriber
- Prescriber shall refer to a high risk obstetrician if the patient becomes pregnant or desires to become pregnant.

I, the undersigned, agree to follow these guidelines and acknowledge that all of my questions and concerns regarding my treatment plan have been adequately answered. I hereby give permission for Dr. Phillip J. Haggerty, M.D. to contact and share information with my other healthcare providers as is deemed necessary for coordinated, quality care. If I do not follow these guidelines fully, my doctor my taper or stop opioid treatment and refer me elsewhere for care.

A copy of this executed document has been given to me to take to the pharmacy listed above.

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____

APMC - Patient Consent for Medical Treatment and Healthcare Messages

I, the undersigned, have read and understand the terms and conditions. I understand that my failure to adhere to any of the standards set forth by the above the contract will result in my immediate termination from this practice.

I, the undersigned, am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize medical care and treatment by Anesthesiology and Pain Management Consultants Inc., through its individual physicians, employees and/or agents. This care and treatment encompasses all diagnostic and therapeutic treatments considered necessary or advisable in the judgement of the physician and provided by Phillip J. Haggerty M.D.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of treatments or examinations performed by Anesthesiology and Pain Management Consultants Inc.

I acknowledge that I have received a copy of Anesthesiology and Pain Management Consultants Inc. notice of privacy practices and I understand that the notice is also posted at each location where services are provided and on the internet at www.apmcinc.net. I consent to be called on my contact number of choice concerning healthcare services rendered to me.

To protect against the transmission of blood-borne diseases such as Hepatitis B and Acquired Immune Deficiency Syndrome, I understand that it may be necessary to test my blood for certain diseases while I am a patient at Anesthesiology and Pain Management Consultants Inc. I understand and consent that my blood, as well as blood of any person accidentally exposed to my blood, will be tested. I further understand that my blood will not be tested for these diseases unless ordered by my physician and that the results will be kept confidential.

I have read this form, or have had it read to me, and I certify that I fully understand and accept its contents unless noted.

I _____ give permission to Anesthesiology and Pain Management Consultants Inc. to leave messages regarding my care in the following manner when I am not available.

PLEASE MARK ALL THAT APPLY

____ May leave appointment reminders, lab results and general information on my answering machine.

____ May leave appointment reminders, lab results and general information with my family.

____ May ONLY leave information with myself. (If you check here, no other choices should be marked.)

____May leave appointment reminders, lab results, and general information with a designated individual. Please leave a specific contact person's name and phone number.

Name: _____ Phone: _____

Patient Printed Name _____Date: _____

Patient Signature _____ Date: _____

Witness Signature _____ Date: _____

APMC - Counseling Form

I have been counseled about the risks of consuming these medications, substances, smoking, body odor, and fragrances and directions / policies of the practice.

- Soma (Carisoprodol) – which is a muscle relaxant
- Xanax / Alprazolam use will not be tolerated in the practice. Diazepam / Valium, Clonazepam, Serax, Ativan, Restoril prescriptions MUST be approved by APMC
- Suboxone / Buprenophine will not be tolerated in the practice.
- Marijuana – whether it is obtained from a state where it's legal, it is still illegal in TN.
- Alcohol – just because it's legal doesn't mean it's ok to consume alcoholic beverages.
- Overtaking my medications – taking more then prescribed, or failing to get clearance to get another narcotic prescription from another healthcare provider (Surgeon etc.).
- Bring your medication to ALL of your appointments. If you fail to bring your medication to your appointment, you will be rescheduled.
- Please refrain from smoking prior to coming to the practice or wearing perfume. The practice doesn't want to be unwelcoming, but several providers are allergic or extremely sensitive to the odors. If the odor is excessive, you will be rescheduled.
- Other _____

Comments:_____

These substances were not prescribed to me and I will not use while prescribed opiate pain medication. These risks may include: sedation, respiratory depression, increased risk of overdose, as well as death. I understand that I will be monitored for additional use. I also understand that APMC Inc. does NOT condone this behavior. Failure to elimanate usage of non-prescribed medications / dangerous substances may be grounds for dismissal from the practice without further discussion, appointments or prescriptions.

Printed Name:_____ DOB:_____

Patient Signature:_____ Date:_____

Witness:_____ Date: _____

Written Warning#_____

Informed Consent: Controlled Substance Treatment **Mandatory** for Chronic Opioid Therapy

Please read the information below carefully and ask your provider if you have any questions relating to the medications prescribed to you.

Using Controlled Medications to Treat Pain

- These medications are used to treat moderate-to-severe pain of any type, and to treat anxiety and stress associated with moderate-to-severe pain.
- These medications are best understood as potentially effective tools that can help reduce pain, improve function, and improve quality of life.
- Using these Medications requires that both the physician and patient work together in a responsible way to ensure the best outcome, lowest side effects, and least complications.
- **Benzodiazepines will not be prescribed by this office** and are contraindicated in opioid use.

How do Opioids Work?

- Opioid Medications work at the injury site, the spinal cord and the brain.
- They dampen pain, but do not treat the underlying injury
- They may help to prevent acute pain from becoming persistent chronic pain.
- These medications may work differently on different people because of a number of factors. Side effects and complications will also individually vary.

What to Expect When You Take Controlled Medications for Pain and Related Conditions

- Pain Relief
- Reduction of anxiety and stress caused by pain
- Side effects

What Should Not Be Expected From Treatment with Controlled Medications

- Cure of the underlying injury
- Total elimination of pain, anxiety, and stress
- Loss of ability to feel other physical pain

Negative Effects of Controlled Medications **Vary in Different People**

Opioid Side Effects

- Common effects include constipation, dry mouth, sweating, nausea, drowsiness, euphoria, forgetfulness, difficulty urinating, itching

- Uncommon effects include confusion, hallucinations, shortness of breath, depression, and lack of motivation

Physical Dependency

- Opioid medications will cause a physical dependency marked by abstinence syndrome when they are stopped abruptly. If these medications are stopped or rapidly decreased the patient will experience chills, goose bumps, profuse sweating, increased pain, irritability, anxiety, agitation and diarrhea. The medicines will not cause these symptoms if taken as prescribed and any decision to stop these medications should be done under the supervision of your physician in a slow downward taper. _____

Misuse of Medications: Addiction

- This is a psychological condition of use of substance despite self-harm. Between six and ten percent of the population of the United States have problems with substance abuse and addiction. Controlled medications are likely to activate behavior in this group of people. _____

Diversion:

- It is **illegal** to share your controlled medications with other people. _____
- It is **illegal** to provide false information to a prescriber in attempt to obtain controlled medication.
- It is **illegal** to doctor shop, or visit multiple doctors in attempt to obtain controlled medications. Federal and state laws exist to address diversion problems.
- It is **critical** that you safeguard your controlled medications and use them only as prescribed by your doctor.

Driving

- Studies of patients with chronic pain demonstrate improved driving skills when taking certain controlled medications, but individuals may have problems driving and need to realistically assess their own driving skills, as well as listen to others who drive with them to determine if they should by driving while taking these medications. You should consult the State Department of Transportation if you have any questions about driving and taking controlled medications. This is especially important if your work involves driving, making important decisions that affect others, etc. _____

Patient Name_____DOB_____ Date_____

APMC Staff Signature_____Date_____

Patient Information Sheet for Narcan

You, your family members and or healthcare givers need to read this information and be informed on what to do if an opioid emergency occurs. The information is provided for you and at any point, please feel free to contact our office with any questions or concerns about your care.

What is Narcan Nasal Spray?

- **Narcan** is a prescription medication used for the treatment of an opioid emergency such as an overdose or a possible opioid overdose with signs of breathing problems, severe sleepiness, or not being able to respond.
- **Narcan** nasal spray is to be given right away and does not take the place of emergency medical care. **Get emergency medical** help right away after giving the first dose of Narcan nasal spray, **even if the person wakes up**.
- **Narcan** nasal spray is safe and effective in children for known or suspected opioid overdose.

What is the most important information I should know about Narcan nasal spray?
Narcan nasal spray is used to temporarily reverse the effects of opioid medicines. The medication has no effect on people who are not taking opioid medicines. Always carry Narcan nasal spray with you in case of an opioid emergency.

1. Use Narcan nasal spray right away if you or your caregiver think signs or symptoms of an opioid emergency are present, even if you are not sure, because an opioid emergency can cause injury or death. Signs and symptoms of an opioid emergency may include:
    - **unusual sleepiness** and you are unable to awaken the person with a loud voice or by rubbing firmly on the middle of their chest (sternum)
    - **breathing problems** including slow or shallow breathing in someone **difficult to awaken** or who looks like they are not breathing
    - the black circle in the center of the colored part of the eye (pupil) is very small, sometimes called **"pinpoint pupils**," in someone difficult to awaken.

2. Family members, caregivers, or other people who may have to use Narcan nasal spray in an opioid emergency should know where Narcan nasal spray is stored, and how to give Narcan before an opioid emergency happens.
3. **Get emergency medical help right away after giving the first dose of Narcan nasal spray.** If needed, **rescue breathing and or CPR (cardiopulmonary resuscitation)** while waiting on emergency help to arrive.
4.The signs and symptoms of an opioid emergency **return** after Narcan is given. If this happens, give **another dose after 2-3 minutes using a new Narcan nasal spray**, and watch the person until emergency personnel arrives and takes over their care.

Do not use Narcan spray if you are allergic to Naloxone hydrochloride or any of the ingredients of Narcan spray.

Before being prescribed Narcan nasal spray by your healthcare provider, please make sure healthcare provider knows about ALL your medical conditions, including if you:

have **heart problems**
are **pregnant or plan on becoming pregnant**
are breastfeeding or plan to breast feed. It is unknown if Narcan nasal spray passes into your breast milk.

How should I use Narcan nasal spray?
Read the **"Instructions for Use"** for detailed information about the right way to use Narcan nasal spray.

- Use Narcan nasal spray **exactly as prescribed** by your healthcare provider.
- Each Narcan nasal spray contains **ONE** dose of medicine and **cannot be reused**.
- Lay the person on their back. Support their neck with your hand and allow the head to tilt back before giving Narcan nasal spray.
- The **total unit dose of Narcan** nasal spray should be sprayed into **one nostril**.
- **If an additional dose of Narcan is needed, give that dose in the other nostril.**

What are the possible side affects of Narcan nasal spray?
Narcan may cause serious side effects, including:

- **Sudden opioid withdrawal symptoms.** In someone who has been using opioid medication regularly, opioid withdrawal symptoms can happen suddenly after receiving Narcan nasal spray may include:
  body aches, sneezing, nervousness, diarrhea, goose bumps, sweating, fever, restlessness or irritability, yawning, runny nose, shivering or trembling, weakness nausea or vomiting, increased blood pressure, stomach cramping, increased heart rate

These are not all of the possible side effects of Narcan nasal spray. Call your doctor and or pharmacist for questions concerning side effects about this medication. You may report side effects to the Food and Drug Administration at 1-800-FDA-1088.

Infants under 4 weeks old who have been receiving opioids regularly, sudden opioid withdrawal may be life threatening if not treated the right way. Signs and symptoms include: seizures, crying more than usual, and increased reflexes.

Narcan should be **stored:**

- At room temperature between 59 F and 77 F.
- The medication can be stored for **short periods** up to 104 F.
- **Do not freeze Narcan**
- Keep Narcan nasal spray in the **manufacturers box and protected from the light**
- **Replace Narcan** nasal spray **before the medication expires. T**he expiration date is located on the box.

Keep Narcan nasal spray and all medications secured and out of the reach of children.

Do not use Narcan for purposes other than those instructed by your healthcare provider.
Active ingredients: naloxone hydrochloride Inactive ingredients: benzalkonium chloride, didsodium ethylenediaminetetraacetate , sodium chloride, hydrochloric acid to adjust the pH and sterile water.

I have been given information regarding Narcan and understand the use and reasons as to why I am being prescribed this medication.

Patient Name (Print):_____Date:_____

Patient Signature:_____DOB:_____

Witness:_____ Date:_____

Notice of Privacy Practices Acknowledgment
APMC, INC.

I understand that under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change it's Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____

Patient Name or Legal Guardian (print) Date

_____

Signature

_____

Witness Date

No Show / Reschedule Policy

When scheduling an appointment with Anesthesiology and Pain Management we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your appointment. This gives us time to schedule other patients who may have been waiting for an appointment. Please see our Appointment Cancellation/ No show Policy below.

- Effective February 1st, 2023 an established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and be charged a **$40.00 fee.**

- Any established patient who continues to No Show after 3 times can be up for dismissal.

- Patients are allowed 3 reschedules in a year without a doctors note. After 3 reschedules if you don't have a doctors note then you will be charged a **$30.00 fee** every time you reschedule.

- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a call or message, the above Policy will still remain in effect.

- **All fees will be due at the time of your next visit, and will be collected with your copay before you are seen.**

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience circumstances please contact our Clerical Manager, who may be able to waive the No Show/ Reschedule fees. You may contact APMC 24 hours a day, 7 days a week at 865-687-3313. Should it be after regular business hours Monday-Thursday, or a weekend, you are able to still leave us a message.

Patient Signature: _____ **Date:** _____

Witness:_____**Date:** _____