MARK A. YOUNG, MD, MBA, FACP

DATE _____

PATIENT NAME _____
LAST FIRST MI
ADDRESS _____
CITY, STATE *ZIP CODE* _____
HOME PHONE _____ WORK PHONE _____
BIRTHDATE _____ SS# _____
MARITAL STATUS _____ SEX ____
OCCUPATION _____ EMPLOYED BY _____
WORK ADDRESS _____

PATIENT REFERRED BY _____ PHONE _____
ADDRESS _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

INSURANCE INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____
IF NOT **SELF**: RELATIONSHIP TO PATIENT _____
ADDRESS _____
HOME PHONE _____ WORK PHONE _____

PRIMARY INSURANCE _____ ID# _____ GROUP# _____
POLICY HOLDER'S NAME _____RELATION TO PATIENT _____
ADDRESS FOR CLAIMS _____
PHONE _____ FAX _____

SECONDARY INSURANCE _____ID# _____GROUP# ____
POLICY HOLDER'S NAME _____RELATION TO PATIENT ____
ADDRESS FOR CLAIMS _____
PHONE _____ FAX _____

IS VISIT THE RESULT OF AN ACCIDENT? __ MVA? __ WORKMANS COMP? ___
DATE OF INJURY _____ INSURANCE _____
CLAIM# _____ HOSPITALIZED? _____
ADJUSTER _____ PHONE _____
ATTORNEY _____ PHONE _____

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION REQUESTED BY HEALTH CARE PROVIDERS OR INSURANCE COMPAINIES FOR THE PROCESSING OF INSURANCE CLAIMS. I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO DR. MARK A. YOUNG. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT MY INSURANCE PAYS FOR ASSIGNMENT. COPY OF THIS FORM IS TO BE CONSIDERED AS AN ORIGINAL.

SIGNATURE _____ DATE _____

DATE: _____ PATIENT NAME: _____

Please fill out the following form that will help us understand the nature and placement of your pain.

I. Is this your first visit? **Please circle: Yes No**
If "No", since your last visit has there been any improvement? **Please circle: Yes No**

II. Circle which word(s) describes the quality of your pain.

dull aching throbbing burning tingling numbness

sharp shooting stabbing other _____

III. Please circle the intensity of your pain:

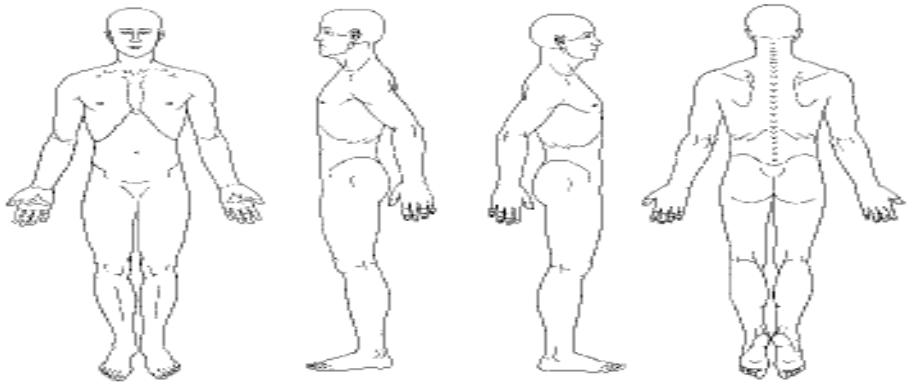
No Pain **Extreme Pain**

0 1 2 3 4 5 6 7 8 9 10

IV. Please circle the numbers below that best describe how pain has interfered with your functioning today.
0 = no interference 10 = completely interferes

General Activity	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Walking Ability	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Normal Work Routine	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Sleep	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Appetite	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Ability to Concentrate	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Enjoyment of Life	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

V. Please mark the part(s) of your body where your pain is located:



***TO BE FILLED OUT AFTER YOUR PROCEDURES TODAY*:**

Please circle the intensity of your pain at this moment:

No Pain **Extreme Pain**

0 1 2 3 4 5 6 7 8 9 10

Name _____
Date _____

How Do You Feel?
Do You Have?

*Please check box.

1. Constitutional

- ☐ Unexpected weight loss
- ☐ Unexpected weight gain
- ☐ Fever
- ☐ Chills
- ☐ Fatigue

2. Eyes

- ☐ Corrective lenses
- ☐ Blurred/ Double vision
- ☐ Eye pain
- ☐ Redness
- ☐ Watering

3. ENT

- ☐ Headache
- ☐ Difficulty swallowing
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Earaches

4. Cardiovascular

- ☐ Chest pain
- ☐ Palpitations
- ☐ Fainting
- ☐ Murmurs

5. Respiratory

- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Lightness
- ☐ Inspiration pain
- ☐ Snoring

6. Gastrointestinal

- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloody/tarry stools

7. Genitourinary

- ☐ Frequency
- ☐ Urgency
- ☐ Difficulty/Painful urination
- ☐ Flank pain
- ☐ Bleeding

8. Musculoskeletal

- ☐ Joint pain
- ☐ Swelling
- ☐ Inability
- ☐ Stiffness
- ☐ Redness
- ☐ Heat
- ☐ Muscle pain

9. Skin

- ☐ Skin changes
- ☐ Poor healing
- ☐ Rash
- ☐ Itching
- ☐ Redness

10. Neurologic

- ☐ Numbness/tingling
- ☐ Unsteady gait
- ☐ Dizziness
- ☐ Tremors
- ☐ Seizure

11. Psychiatric

- ☐ Nervousness
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations

12. Hematologic

- ☐ Easy bleeding
- ☐ Bruising

13. Endocrine

- ☐ Excessive thirst or urination
- ☐ Heat/Cold intolerable

14. Allergic

- ☐ Reaction to foods or environment

If so, which _____
_____
_____

MEDICATION LIST

NAME _____ DATE _____
PHONE _____ DOB _____

MEDICATION	***STRENGTH***	HOW IS IT TAKEN?

Office of MARK A. YOUNG, MD, FACP

NAME _____ AGE _____ BIRTH DATE __ / __ / __ GENDER _____ TODAY'S DATE _____

FAMILY HISTORY

CHECK BOX ONLY IF ANY HAVE:	FATHER AGE ___	MOTHER AGE ___	SISTERS # ____ BROTHERS # ____	SPOUSE AGE ___	CHILDREN #____ AGES _____	GRAND-PARENT
CANCER						
TUBERCULOSIS						
DIABETES						
HEART TROUBLE						
☐ HIGH ☐ LOW BL00D PRESSURE						
☐ STROKE ☐ SEIZURES						
MENTAL HEALTH PROBLEMS						
ASTHMA / HIVES / HAYFEVER						
BLOOD DISEASE						

IF ANY DECEASED:

AGE AT DEATH	CAUSE OF DEATH	WHO?

PERSONAL HISTORY

HAVE YOU EVER HAD	YES	HAVE YOU EVER HAD	YES	HAVE YOU EVER HAD	YES
☐ SCARLET FEVER ☐ SCARLATINA		☐ GONORRHEA ☐ SYPHILIS ☐ HERPES / STDs		☐ BROKEN ☐ CRACKED BONES	
DYPHTHERIA		ANEMIA		RECURRENT DISLOCATIONS	
CHICKEN POX		JAUNDICE		CONCUSSION	
PNEUMONIA		☐ EPILEPSY ☐ SEIZURES		KNOCKED UNCONSCIOUS?	
CHRONIC LUNG DISEASE		MIGRAINE HEADACHES		☐ FOOD ☐ CHEM POISONG	
PLEURISY		TUBERCULOSIS		DRUG POISONING	
KIDNEY DISEASE		DIABETES		POSITIVE HIV TEST	
RHEUMATIC FEVER		CANCER		OSTEOPOROSIS	
HEART DISEASE		☐ HIGH ☐ LOW BLOOD PRESSURE		OTHER : _____	
☐ ARTHRITIS ☐ RHEUMATISM		MENTAL HEALTH PROBLEMS		*COMPLEMENTARY THERAPY*	
☐ BURSITIS ☐ SCIATICA		☐ HAY FEVER ☐ ASTHMA		EXPLAIN	
LUMBAGO		☐ HIVES ☐ ECZEMA		WEIGHT: NOW _____	
☐ POLIO ☐ MENINGITIS		FREQUENT ☐ COLDS ☐ SORE THROAT		ONE YEAR AGO _____	
ANY ☐ BONE ☐ JOINT DISEASE		FREQUENT ☐ INFECTIONS ☐ BOILS		MAXIMUM WEIGHT _____	

ALLERGIES

ARE YOU ALLERGIC TO	YES	ARE YOU ALLERGIC TO	YES	ARE YOU ALLERGIC TO	YES
☐PENCILLIN ☐ MYCINS ☐ OTHER		SULFA DRUGS		☐ NAILPOLISH ☐ OTHER COSMETICS	
☐ CODEINE ☐ MORPHINE		☐ TETANUS ☐ ANTITOXIN ☐ SERUMS		OTHER DRUGS _____	
ASPIRIN		☐ ADHESIVE TAPE ☐ LATEX		ANY FOODS _____	

SURGERY

HAVE YOU HAD REMOVED	YES	DATE	HAVE YOU HAD REMOVED	YES	DATE	HAVE YOU HAD	YES	DATE
TONSILS			UTERUS			HERNIA REPAIRED		
APPENDIX			☐ OVARY ☐ OVARIES			TRANSFUSION		
GALL BLADDER			TUMOR _____			BEEN HOSPITALIZED		
HEMORRHOIDS			OTHER _____			EXPLAIN		

X-RAYS

EVER HAD X-RAY OF	YES	DATE	EVER HAD	YES	DATE	EVER HAD	YES	DATE
☐ CHEST ☐ STOMACH			MRI OF _____			MAMMOGRAM		
☐ GALL BLADDER ☐ COLON			CT SCAN OF _____			DEXA BONE SCAN		

☐ BACK ☐ EXTREMITIES			ULTRASOUND OF _____			OTHER: _____		

Mark A. Young, MD, FACP

4000 Old Court Road, Suite 105
Baltimore, MD 21208
410-602-6272

617 Stemmers Run Road, Suite 1A
Essex, MD 21221
410-686-6355

Pain Management Agreement

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

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

I understand that if I break this Agreement, my doctor will stop prescribing these pain-control medicines.

In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I agree to tell my doctor my complete and honest personal drug history.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell or trade my medication with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.

I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

I agree to use_____ Pharmacy,

located at_____ ,

telephone number _____ , for filling prescriptions for all of my pain medicine.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unused pain medicine to every office visit.

>>> **OVER** >>>>>>>>>>>>>>>>>>>

PAIN MANAGEMENT AGREEMENT (CONT.)

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I don not notice it, my reflexes and reaction time might still be slowed.

I am aware that certain other medicines such as nalburphine (Nubain tm), pentazocine (Talwin tm), buprenorphine (Buprenex tm) and butorphanol (Stadol tm) may reverse the action of the medicine I am using for pain control.

I am aware that the use of such medicine has certain risks associated with it including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I understand that if my pain medicines use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

MALES ONLY: I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that I may need to have my blood checked to see if my testosterone level is normal.

FEMALES ONLY: If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

I agree to follow these guidelines that have been fully explained to me. I have read this form or have had it read to me. I understand all of it. All of my questions and concerns regarding treatment have been adequately answered. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines. A copy of this document has been given to me.

This Agreement is entered into on this date: _____

Patient signature:_____

Physician signature: _____

Witnessed by: _____

Mark A. Young, MD, FACP

Board Certified, Physical Medicine & Rehabilitation
Licensed Acupuncturist
Electrodiagnosis

4000 Old Court Road, Suite 105 Baltimore, MD 21208
617 Stemmers Run Road, Suite 1A Essex, MD 21221

I have received from the office of Dr. Mark A. Young the NOTICE OF PRIVACY PRACTICES on this date, _____ , 2008.

I have read and understood this information.

Sign: _____

Print: _____

INSTRUCTIONS: PLEASE SIGN ABOVE
AND RETURN THIS PAGE TO FRONT DESK

Mark A. Young, MD, FACP
Board Certified, Physical Medicine & Rehabilitation
Licensed Acupuncturist / Electrodiagnosis

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

OUR PROMISE TO YOU, OUR PATIENTS

1. **Your information is confidential.**
2. **Your information is important and confidential. Our policies require that your information be held in strict confidence.**

INTRODUCTION

We maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords to protect databases, compliance audits and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs.

At the practice of Mark A. Young, MD, FACP, we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Policies describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR HEALTH RECORD

Each time you visit the practice of Mark A. Young, MD, FACP, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you received.
- Means by which you or a third-party payer can verify that services billed were actually provided.
- Tool in educating health professionals.
- Source of data for medical research.
- Source of information for public health officials charged to improve the health of the state and nation.
- Source of data for our planning and marketing.
- Tool by which we can assess and continually work to improve the care we render and outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where and why others may access your health information; and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Mark A. Young, MD, FACP, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of privacy policies upon request.
- Inspect and copy your health record as provided by 45 CFR 164.524.
- Amend your health record as provided by 45 CFR 164.526.
- Obtain an accounting of disclosures of your health information as provided by 45 CFR 164.528.
- Request confidential communications of your health information as provided by 45 CFR 164.522.
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522 (the practice, however, is not required by law to agree to a requested restriction).

OUR RESPONSIBILITIES

The practice of Mark A. Young, MD, FACP is required to:

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate your health information.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top, right-hand corner. In addition, each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request.

We will not use or disclose your health information in a manner other than described in the section regarding Examples Of Disclosures For Treatment, Payment And Health Operations, without your written authorization, which you may revoke as provided by 45 CFT 164.508(b)(5), except to the extent that action has already been taken.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

1. If you have questions and would like additional information, you may contact our practice's Privacy Officer, Debra Walters, at 410-602-6272.

2. If you believe your privacy rights have been violated, you can either file a complaint with Debra Walters, or with the Office for Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our Privacy Officer or the OCR. The address for the OCR is as follows: Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS

We will use your health information for treatment.

For example:

Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will use your health information for regular health operations.

For example:

Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates

There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory testes and a transcription service we use to transfer dictated patient care into the medical record. Dr to the nature of business associates' services, they must receive your health information in order to perform the jobs we've asked them to do. To protect your health information, however, when these services are contracted we require the business associate to appropriately safeguard your information.

Research

We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors

We may disclose health information to funeral directors to carry out their duties consistent with applicable law.

Organ Procurement Organizations

Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Fundraising

We may contact you as part of a fund-raising effort.

Food & Drug Administration (FDA)

We may disclose to the FDA health information relative to adverse events wit respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation

We may disclose health information to the extent authorized by and necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health

As required by law, we may disclose your health or legal authorities charged with preventing or controlling disease, injury, or disability.

Appointment Reminders

We may contact you or a family member at the phone number you have provided to us as a reminder that you have an appointment.

Marketing

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Directory

Unless you notify us that you object, we will use your name, location in the facility and general condition for our directory purposes. This information may be provided to members of your family and to other people who ask for you by name.

Notification

We may use or disclose information to notify or assist in notifying a family member or personal representative (or other person responsible for your care) of your location and general condition.

Communication With Family

Health professional, using their best judgment, may disclose to a family member, other relative, or close personal friend (or any other person you identify) health information relevant to that person's involvement in your care or payment related to your care.

Law Enforcement

WE MAY DISCLOSE HEALTH INFORMATION FOR LAW ENFORCEMENT PURPOSES AS REQUIRED BY LAW OR IN RESPONSE TO A VALID SUBPOENA. We will also provide your other physician(s) or subsequent health care provider(s) (when applicable) with copies of various reports that should assist them in treating you.

We will use your health information for payment.

For example:

A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, orders, or the public.