Pain & Spine
Associates of Texas

Pain & Spine Associates of Texas, PLLC

Patient Name:_____ **DOB**_____

Chief Complaint:_____When did it start?____/____/____

HISTORY OF PRESENT ILLNESS: (circle all that apply)

Pain is: improving / worsening / stable / constant / intermittent
Pain is due to: car accident / work injury / sports injury / old age / disease / other
Is there a lawsuit or workers compensation claim? YES / NO

What worsens the pain? Standing / Sitting / Lying down / Walking / Twisting / Driving
Reaching / Change in weather / Cough / Sneeze / Leaning forward
Leaning backward / Other:

What reduces the pain? Standing / Sitting / Lying down / Walking / Twisting / Driving
Reaching / Heat / Cold / Leaning forward / Leaning backward / Other:

Is there new or different: weakness (not pain related)
loss of feeling
bowel/bladder incontinence (accidents)?

Reduced sleep: Yes / No Does your pain make you feel: depressed / angry / anxious

Prior therapies, injections, treatments: (circle all that apply) Physical Therapy / MRI / CT scan / EMG / Xray /
Discogram / Epidural / Other injection / Narcotics

Current Physicians:
PCP:_____ Surgeon:_____
Other:_____ Prior Pain Physicians: _____

PAST MEDICAL HISTORY:

Diabetes Heart disease Blood pressure Cancer Stroke
Asthma Emphysema Liver disease Kidney disease Ulcers
Depression Anxiety Thyroid disease Other:

PAST SURGICAL HISTORY:

Appendix	Gall bladder	CABG/Angioplasty
Hysterectomy	Hernia repair	Tonsillectomy
Neck surgery	Back Surgery	Other surgery:

MEDICATIONS: _____ _____
_____ _____

PEG Scale Assessing Pain Intensity and Interference (Pain, Enjoyment, General Activity)

1. What number best describes your pain on average in the past week?

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0	1	2	3	4	5	6	7	8	9	10
	Does not interfere									Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0	1	2	3	4	5	6	7	8	9	10
	Does not interfere									Completely interferes

Computing the PEG Score.

Add the responses to the three questions, then divide by three to get a mean score (out of 10) on overall impact of points.

Using the PEG Score.

The score is best used to track an individual's changes over time. The initiation of therapy should result in the individual's score decreasing over time.

Source.

Krebs, E. E., Lorenz, K. A., Bair, M. J., Damush, T. M., Wu, J., Sutherland, J. M., Asch S, Kroenke, K. (2009). Development and Initial Validation of the PEG, a Three-item Scale Assessing Pain Intensity and Interference. Journal of General Internal Medicine, 24(6), 733–738. http://doi.org/10.1007/s11606-009-0981-1

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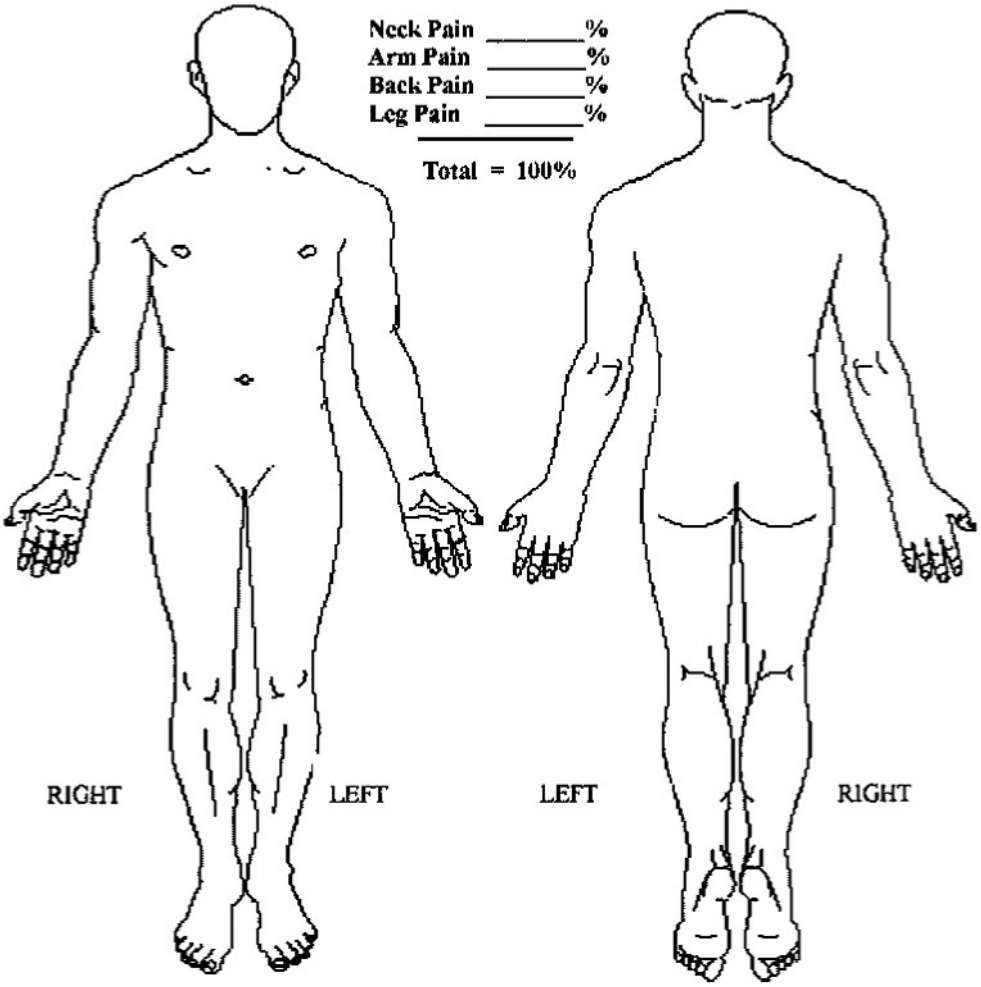
PATIENT: _____ **AGE:**_____ **DATE:** _____

WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol.

ACHE ^	NUMBNESS O	PINS & NEEDLES ■	BURNING X	STABBING +



How bad is your pain now?

❶_____❷_____❸_____❹_____❺_____❻_____❼_____❽_____❾_____❿

NO PAIN **INTERMEDIATE PAIN** **WORST PAIN**

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_____ _____

_____ _____

PRIOR PAIN MEDICATIONS:_____

OTC MEDICATION: Aspirin / Motrin / Advil / Aleve / Goody's / BC Powder / Other:

ALLERGIES: Drug: _____ **Reaction :** _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY:

Married / Single / Divorced / Widowed Do you have children (how many)?_____
Alcohol use: None / Social / Daily (more than 2 drinks) Quit:
Tobacco: None or ___ packs per day x ___ years Quit:
Street Drugs:_____Current / Prior
Education: Grade school / HS / GED / Trade school / College / Post-grad
Occupation: Last worked:
Hobbies: Goals of treatment:

FAMILY HISTORY:

Genetic diseases / Neurological disease / Muscle disease / Stroke / Alcoholism or illegal substance abuse

REVIEW OF SYSTEMS: (*only circle if new complaint*)

Weight loss / Fever / Dizziness / Recent change in vision or double vision / Chest pain / Shortness of breath / Cough / Wheezing / Heartburn / Nausea / Vomiting / Diarrhea / Constipation / Bloody stools / Black stools / Blood in the urine / Rash / Easy bruising / New onset seizures / Recent memory loss / Hot or cold temperature intolerance / IV drug abuse / Suicidal thoughts / Sexual problems or decreased libido / Fatigue / Headache

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Name:_____ DOB:_____/_____/_____

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

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	Rarely	Sometimes	Often	Very Often
	0	1	2	3	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 to 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 then 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?					

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Suite 404
Pearland, TX 77584
www.painandspinetexas.com
info@painandspinetexas.com

Pain & Spine
Associates of Texas

Name:_____ DOB:_____/_____/_____

	Never	Rarely	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?					
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 others expressed concern over your use of medication?					

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

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NEW/UPDATED PATIENT INFORMATION FORM

☐New Patient ☐Updated Information

Pain & Spine Associates of Texas

Patient Demographics

Patient Name: _____ Birth Date: _____/_____/_____

Social Security No: _____-_____-_____ Gender: ☐Male ☐Female

Address: _____

Home #: _____-_____-_____ Cell #:_____-_____-_____ Work #:_____-_____-_____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed Preferred Language: _____

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

Ethnicity: ☐Hispanic or Latin Decent ☐Not Hispanic or Latin Decent ☐Do Not Wish to Report

Emergency Contact Information

Name: _____ Phone: _____-_____-_____

Release of Medical Information

(Medical Information may be released to the following individuals)

Name: _____ Relationship: _____ Phone: _____-_____-_____

Name: _____ Relationship: _____ Phone: _____-_____-_____

Payment Information

Form of Payment: ☐Health Insurance ☐Auto Insurance ☐Workers Comp ☐Self-Pay ☐Other

Primary Insurance

Primary Company: _____ Insured's Name: _____

Policy #: _____ Group #: _____ Insured's Date of Birth: _____/_____/_____

Secondary Insurance

Primary Company: _____ Insured's Name: _____

Policy #: _____ Group #: _____ Insured's Date of Birth: _____/_____/_____

Self-Pay Agreement

I agree to pay for medical services rendered from Pain & Spine Associates of Texas, PLLC and/or its affiliated providers. I understand that payment arrangements must be made prior to establishing as a new patient.

Patient Signature:_____ Date: _____/_____/_____

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION:

I authorize Pain & Spine Associates of Texas, PLLC ("Practice") and its affiliated providers to release any medical information requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment of my medical care.

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFIT:

I authorize the release of any medical information necessary to process any claim associated with the Practice and affiliated providers with respect to my medical care. I permit a copy of this authorization to be used in the place of the original.

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment of benefits to be paid directly to the affiliated providers of the Practice. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits, when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment, including attorney's fees.

CONSENT FOR TREATMENT:

I authorize the Practice and its affiliated providers to perform a physical examination and to provide any medical treatment deemed necessary. This includes but not limited to all required medical examinations, lab tests, x-rays, and/or medical / surgical procedures.

PATIENT PAYMENT RESPONSIBILITY:

I agree that all applicable fees, deductibles, co-insurance, and co-payments are my responsibility and must be paid at the time services are rendered, unless payment arrangements have been made.

APPOINTMENT CANCELLATIONS:

I agree to make every attempt to call the office at least 24 hours in advance of any appointment that needs to be cancelled or rescheduled. The Practice reserves the right to assess a $25 missed appointment fee if an appointment is cancelled or rescheduled with less than 24 hours' notice, and I agree to pay this fee.

POLICY REGARDING LEGAL MATTERS:

I agree that the Practice and its affiliated providers have not agreed or consented to provide services other than medical services. In particular, the Practice and its affiliated providers have not agreed or consented to participate or be a witness in any legal matter (examples: a car wreck suit, a worker's compensation proceeding, a divorce suit, a criminal case), and I agree not to subpoena or call the Practice or any of its affiliated providers as a witness in any legal matter. In the event that the Practice or any of its affiliated providers is subpoenaed or called as a witness in any legal matter in relation to my care or treatment, I agree that the Practice shall be entitled to additional compensation for all reasonable time and expense incurred by or on behalf of the Practice or any of its affiliated providers in relation to the matter, including $750/hour for each hour reasonably spent by any physician of the Practice in relation to the matter. This policy does not preclude you from obtaining copies of your medical records. Upon receipt of a proper request the Practice can provide a business records affidavit to go with medical records.

CHANGE OF INFORMATION:

I agree to provide the office any information regarding changes in my address, phone number, health benefits, or insurance information.

NOTICE OF PRIVACY PRACTICES:

The Practice and affiliated providers are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Signing below indicated acknowledgement of receipt of our office's Notice of Privacy Practices.

AUTHORIZED SIGNATURE:

I authorize that I have read this document and will comply with the policies listed above. I also understand and agree that the Practice and affiliated providers reserve the right to terminate the physician/patient relationship for non-compliance with any of the above policies.

Patient Name (Please Print):

_____

Patient Signature:

_____

Date: _____ /_____ / _____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the Pain & Spine Associates of Texas, PLLC ("Practice") and its affiliated providers to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Our HIPAA Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Practice and its affiliated providers reserve the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Administrator.

With this consent, the Practice and its affiliated providers may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the Practice and its affiliated providers may mail to my home or their alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the Practice and its affiliated providers may e-mail to my home or other alternative location any times that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the Practice and its affiliated providers restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting that the Practice and affiliated providers may use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the Practice and its affiliated providers may decline to provide treatment to me.

_____

Print Patient's Name

_____

Print Name Legal Guardian

_____

Signature of Patient or Legal Guardian

_____

Date

Pain & Spine Associates of Texas, PLLC

HIPAA Notice of Privacy Practices

Effective: March 2018

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.**

SUMMARY–

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues

- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us through our privacy officer:

  Pain & Spine Associates of Texas, PLLC

  Attn: HIPAA Privacy Officer

  _____

  _____, Texas _____

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

SIGNATURE

By your signature below, you acknowledge that you have read and received a copy of this Notice of Privacy Practices.

Signature Date

Patient Name (please print)

Pain & Spine
Associates of Texas

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170

3Rd Edition: Developed by the Texas Pain Society, April2008 (www.texaspain.org)

NAME OF PATIENT: _____ DATE: _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform

the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from your care.

For female patients only:

To the best of my knowledge **I am NOT pregnant.**

If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant.

If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/ fetus / baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:

That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued**.
- I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.
- I will use the medication(s) **exactly as directed by my physician**.
- I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will **not allow or assist in the misuse/diversion of my medication; nor will I give or sell them** to anyone else.
- All medication(s) must be obtained at **one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. **If either are lost or stolen, they may NOT BE REPLACED.**
- Refill(s) **will not be ordered before the scheduled refill date**. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s)**. I will not hold my physician liable for problems caused by the discontinuance of medication(s).
- I **agree to submit to urine, saliva and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, meth, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.
- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active**

- **participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.
- I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

I certify and agree to the following:

1) I am **not currently using illegal drugs or abusing prescription medication**(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

2) I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

3) **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

_____

Patient Signature

_____

Physician Signature (or Appropriately Authorized Assistant)

_____

Witness

_____

Name and Phone Number information for pharmacy

Pain & Spine Associates of Texas

Vaibhave Y. Parikh, M.D.

Medical Records Release

ALL ITEMS ON THIS AUTHORIZATION MUST BE COMPLETED IN FULL.

Patient's Name: _____

Date of Birth: _____ Phone: _____

Address _____

_____

The information is to be released to:

Name: Pain & Spine Associates of Texas

Address: 2743 Smith Ranch Rd., Suite 404
Pearland, TX 77584

Phone: (713) 955-3755 Fax: (855) 865-3826

The information I wish to have released (included dates of service)

_____	History & Physical	_____	Reports & Operation
_____	Reports & Diagnosis	_____	Cardiac & EKG Reports
_____	Imaging Reports (CT, MRI, X-Ray)	_____	Laboratory Reports
_____	Audiograms	_____	All Records
	Do not copy anything related to:	_____	

This authorization will automatically expire one year from the date signed. I understand that I can revoke this authorization at any time. I understand that a revocation is not effective to the effective to the extent that any person or entity has already acted in reliance or my authorization of if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Patient Signature or Personal Rep: _____ Date: _____

IF SIGNATURE IS OTHER THAN PATIENT, PLEASE EXPLAIN YOUR AUTHORITY TO ACT FOR THIS PATIENT

Witness Name: _____ Date: _____

Pain & Spine
Associates of Texas

Cancellation Policy/No Show Policy for Doctor Appointments and Procedure/Outstanding Balances

Cancellation / No Show Policy for Doctor Appointment

1. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty-dollar ($50) fee; this will not be covered by your insurance company.

2. Scheduled Appointments: We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient Is 15 minutes past their scheduled time, we will have to reschedule the appointment.

3. Cancellation/No Show Policy for Procedure
Due to limited space available for each patient to help manage their medical needs, last minute cancellations can cause problems and added expenses for the office.

If Procedure is not cancelled at least 24 hours in advance you will be charged a Hundred and Fifty-dollar ($150) fee; this will not be covered by your insurance company.

4. Patients with outstanding balance on their account must make payment arrangements prior to their future appointments. Our practice representative will collect the full amount prior to receiving further services by our doctor. Patients who have questions about their account balance may contact our office at 713-955-3755. Our office hours are Monday to Friday 8-6pm. Thank You.

_____	_____	____/____/____
Print Patient Name	Signature Patient/Guardian	Date