Information on New Consultation Appointments

We are pleased that you have been referred to our office. As part of the initial appointment, we will need you to fill out paperwork that pertain to your medical history; insurance coverage and contact information. We request that you have this filled out by the time you check in to our office to make this process easier for you. This paperwork can be down loaded from our wed site. Otherwise, arriving **45 minutes** before you appointment time should allow enough time to fill out paperwork and check in. We request that you bring all your medications, including over the counter medications, picture ID card and insurance cards. If your address on the picture ID is not correct, we will need a recent utility bill with the correct address.

At your initial appointment, our purpose is to do a complete evaluation, to include a clinical review of x-rays reports/films that have been taken recently that relate to your pain concerns. Without this information, we can not perform a comprehensive evaluation and review options for your care. Therefore, we may need to schedule a second appointment to obtain records/information that was not provided by yourself or the referring physician office. We may also need to order current radiological examinations, lab work, etc. if needed to complete our evaluation. Please note it is not our protocol to order medication for you during the evaluation process. If medication is part of your treatment plan, then that will be discussed along with protocols on how these medications are managed through our office.

Once a complete evaluation is done, we will discuss treatment options and if you wish to proceed with our care, accept you as a patient into our office. This is the point in which the patient/ provider relationship will begin. Please be assured that the evaluation is kept in the strictest of confidence. We understand that you have the option to not pursue a relationship as a patient. We also reserve the right to accept you as a patient once we determine that we can be of assistance.

We hope this information is helpful and look forward to working with you.
Sincerely,
Premier Pain Consultant Management

____ __________

Patient signature of acknowledgement date

PREMIER PAIN CONSULTANTS, P.A.

PATIENT INFORMATION

REFERRED BY: ______________________ E-MAIL ADDRESS: ______________________

1) LAST NAME (*PASADO*) ______________ 2) FIRST NAME (*PRIMERO*) ______________ 3) MI ________

4) ADDRESS (*DIRECCION*) ______________________

5) CITY (*CIUDAD*) ______________ 6) STATE (*ESTADO*) ______________ 7) ZIP ________

8) HOME # (____) __________ 9) WORK # (____) __________ 10) CELL # (____) __________

11) AGE ______ 12) DATE OF BIRTH ____/____/____ 13) SEX ☐M ☐F 14) SOC. SEC. # ______-______-______

15) MARITAL STATUS: ☐S ☐M ☐D ☐W 16) SPOUSE'S NAME ______________________

17) TYPE OF INSURANCE? ☐AUTO ☐WORKER'S COMP. ☐PERSONAL INJURY ☐NONE

EMPLOYER INFORMATION

1) OCCUPATION: ______________________
2) EMPLOYER: ______________________
3) ADDRESS: ______________________
4) CITY: ______________ 5) STATE: ______________ 6) ZIP: ______________
7) BUSINESS PHONE #: ______________ 8) FAX # ______________

AUTO INJURY / WORK INJURY/ PERSONAL INJURY INFORMATION

1) INSURANCE TYPE: ☐AUTO ☐WORKER'S COMP. ☐LIEN ☐______________

2) PATIENT'S RELATIONSHIP TO INSURED: ☐SELF ☐SPOUSE ☐CHILD ☐ ______________

3) DATE OF INJURY: ______________ 4) DESCRIBE HOW INJURY HAPPENED: ______________

____

____

5) COMPENSABLE AREAS: ☐NECK ☐ LOW BACK ☐ ARM PAIN ☐ LEG PAIN ☐ OTHER: ______________

6) NAME OF INSURANCE COMP. :______________________ 7) INS. PHONE #: ______________

8) INS. CO. ADDRESS: ______________________

CITY: ______________ STATE: ______________ ZIP: ______________

9) POLICY #: ______________________ 9) CLAIM #: ______________________

10) WORKER'S COMP. #: ______________________

11) <u>EMPLOYER'S ADDRESS AT TIME OF INJURY:</u> ______________________

CITY______________ STATE ______________ ZIP______________

PHONE # ______________ FAX # ______________

12) DID YOU REPORT INJRY? ☐YES ☐NO TO WHOM? ______________________

13) HOSPITALIZED? ☐YES ☐NO WHERE? ______________ 14) X-RAY TAKEN? ☐YES ☐NO

15) TESTS PERFORMED: ☐ MRI ☐ BONE SCAN ☐ CT SCAN ☐ DISCOGRAM

16) WERE YOU WORKING AT THE TIME OF THE ACCIDENT? ☐YES ☐NO 17) DATES LOST FROM WORK ______________

18) NAME OF DOCTORS SEEN FOR THIS INJURY: ______________________

19) NAME OF TREATING DOCTOR: ______________ 20) DO YOU WORK NOW: ☐YES ☐NO

21) CURRENT WORK STATUS: ☐ FULL-TIME ☐ PART-TIME ☐ OFF WORK/UNABLE TO WORK

22) NATURE OF CURRENT WORK:
☐ FREQUENT HEAVY LIFTING/HEAVY MANUAL LABOR ☐ LIGHT MANUAL LABOR ☐ NO MANUAL LABOR

23) DID YOU HAVE SURGERY FOR THIS PAIN PROBLEM: ☐YES ☐NO IF YES LIST SURGERIES AND SURGEONS:

____

24) IF AUTO INJURY WERE YOU? ☐DRIVER ☐PASSANGER ☐PEDESTRIAN ☐ ______________

25) # OF PEOPLE IN YOUR VEHICLE?: ________ 26) WORE SEAT BELT? ☐YES ☐NO 27) DID AIRBAG INFLATE?☐YES ☐NO

<u>28) NAME OF ATTORNEY______________ 29) ATTY'S PHONE # ______________ 30) ATTY'S FAX ______________</u>

PREMIER PAIN CONSULTANTS, P.A.

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

MARK ON THE PICTURE WHERE YOU ARE HAVING PAIN. ALSO MARK (**X**) FOR NUMBNESS, (**T**) FOR TINGLING, (**B**) FOR BURNING.

1) Is your pain mostly in your: ☐ neck ☐ arm ☐ about the same **OR** ☐ back ☐ leg ☐ about the same

2) How bad are your symptoms at their: (None – Unbearable)

- a. Today 0 ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
- b. Best 0 ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
- c. Worst 0 ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

3) Duration of pain:
☐ < 1 week ☐ 1-4 weeks ☐ 1-3 months
☐ 3-6 months ☐ 6-12 months ☐ > 1year

4) How and when did pain begin? ____________________(month/year)
☐ Work Accident ☐ Following surgery
☐ Home accident ☐ Other accident or injury
☐ Auto accident ☐ Unknown
☐ Other: ____

5) How has pain intensity changed since it began
☐ Increased ☐ Decreased ☐ No change

6) How often does the pain occur?
☐Continuously ☐Constantly (76-100% of the day) ☐Frequently (51-75% of the day) ☐Occasionally (26-50% of the day)
☐Intermittently (0-25% of the day) ☐Less than daily ☐Weekly ☐Monthly

7) Select one or more items below to describe the nature of your pain:
☐ Throbbing ☐ Shooting ☐ Sharp ☐ Cramping ☐ Hot/Burning
☐ Aching ☐ Stabbing ☐ Tingling ☐ Numbing ☐ Dull ache

8) How do the following factors affect your pain? (check only one blank per number)

	Better	Worse	No effect		Better	Worse	No effect		Better	Worse	No effect
a. Heat	☐	☐	☐	g. Climate	☐	☐	☐	m. Sleeping on back	☐	☐	☐
b. Cold	☐	☐	☐	h. Fatigue	☐	☐	☐	n. Sleeping on stomach	☐	☐	☐
c. Lying down	☐	☐	☐	i. Coughing	☐	☐	☐	o. Straining	☐	☐	☐
d. Sitting	☐	☐	☐	j. Massage	☐	☐	☐	p. Sex	☐	☐	☐
e. Walking	☐	☐	☐	k. Alcohol	☐	☐	☐				
f. Sneezing	☐	☐	☐	l. Lifting	☐	☐	☐				

9) Which of the following activities are affected by your pain?
☐ Mood ☐ Activities of daily living ☐ Social interactions ☐ Household chores ☐ Sexual Activity
☐ Work ☐ Falling asleep ☐ Staying asleep ☐ Leisure ☐ Ability to enjoy life

10) Do you have any: ☐ Urinary incontinence ☐ Stool incontinence ☐ Sexual function disturbance

PREMIER PAIN CONSULTANTS, P.A.

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE (CONT.)

11) Check the treatments you have had for pain, please provide treatment dates:

- ☐ Accupuncture: ____________
- ☐ Exercise: ____________
- ☐ Facet Blocks: ____________
- ☐ Trigger Points: ____________
- ☐ Chiropractor: ____________
- ☐ Other: ____________
- ☐ Physical Therapy: ____________
- ☐ Psychotherapy: ____________
- ☐ Epidurals: ____________
- ☐ Massage: ____________
- ☐ Brace: ____________
- ☐ Biofeedback: ____________
- ☐ TENS unit: ____________
- ☐ Nerve Blocks: ____________
- ☐ Hypnosis: ____________
- ☐ Surgery: ____________

PAST MEDICAL HISTORY	REVIEW OF SYSTEMS
Constitutional	
☐ Obesity ☐ Weight loss ☐ Weight gain	☐ Chills ☐ Fever ☐ Fatigue
Musculoskeletal	
☐ Arthritis ☐ Fibromyalgia ☐ Muscle spasms	☐ Numbess ☐ Weakness
Neurological	
☐ Headache ☐ Seizures ☐ Migraines ☐ Stroke	☐ Confusion ☐ Dizziness ☐ Light Sensitivity ☐ Loss of consciousness
Psychiatric	
☐ Depression ☐ Substance Abuse ☐ Anxiety ☐ Bipolar ☐ Schizophrenia	☐ Anxiety ☐ Suicidal thoughts ☐ Difficulty Sleeping
Cardiovascular	
☐ Angina ☐ Heart Attack ☐ Heart Stent ☐ Pacemaker ☐ High Blood Pressure (Hypertension)	☐ Chest Pain ☐ Palpitations
Respiratory	
☐ Asthma ☐ Emphysema ☐ Chronic Bronchitis ☐ Lung Cancer	☐ Cough ☐ Shortness of Breath ☐ Bloody Cough
Gastrointestinal	
☐ Reflux ☐ Hepatitis ☐ Ulcers ☐ Incontinence ☐ Irritable Bowel Syndrom ☐ Cirrhosis ☐ Diverticulitis ☐ Colon Cancer	☐ Diarrhea ☐ Constipation ☐ Abdominal Pain ☐ Heartburn ☐ Bloating ☐ Nausea ☐ Vomiting ☐ Bloody Stools ☐ Painful Bowel Movement
Genitourinary	
☐ Impotence ☐ Kidney Stones ☐ Incontinence ☐ Urinary Tract Infection ☐ Cancer	☐ Decreased Libido ☐ Urinary frequency ☐ Bloody Urine ☐ Prostate Problems ☐ Urinary hesitancy
Integumentary	
☐ Herpes Zoster/Shingles ☐ Skin Cancer	☐ Rash ☐ Swelling
Endocrine, Hematologic, Allergy/Immunologic, HEENT	
☐ Diabetes ☐ Hypothyroidism ☐ Hyperthyroidism ☐ HIV ☐ Hyperlipidemia (Elevated Cholesterol) ☐ Leukemia ☐ Lymphoma ☐ Multiple Myeloma ☐ Cancer: ____________	☐ Easy Bruising ☐ Ringing in Ears ☐ Visual Changes
Rheumatologic	
☐ Lupus ☐ Sjogren's ☐ Scleroderma ☐ Polymyalgia Rheumatica ☐ Rheumatoid Arthritis ☐ Multiple Sclerosis ☐ Other: ____________	☐ Painful joints ☐ Blurry Vision

12) Do you have ALLERGIES to any medications? ☐ YES ☐ NO
If YES please list: ____________

13) Do you smoke? ☐ YES ☐ NO **How many packs per day?** ____________ **How many years?** ____________

14) Do you drink alcohol? ☐ YES ☐ NO **How much per days?** ____________ **How many years?** ____________

15) Do you use illicit drugs ☐ YES ☐ NO **How much per days?** ____________ **How many years?** ____________

PREMIER PAIN CONSULTANTS, P.A.

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE (CONT.)

16) PAST SURGICAL HISTORY (mark and list surgeries that you have, please provide approximate date):

☐ Appendectomy ____	☐ Tonsillectomy/Adenoids ____	☐ Gallbladder surgery ____
☐ Coronary Bypass ____	☐ Hernia Repair ____	☐ Hemorrhoid ____
☐ Tubal Ligation ____	☐ Mastectomy ____	☐ Hysterectomy and ovaries ____
☐ Breast Biopsy ____	☐ Prostate ____	☐ Vasectomy ____
☐ Knee Replacement ____	☐ Hip Replacement ____	☐ Knee Surgery ____
☐ Shoulder Surgery ____	☐ Cataracts ____	☐ Colon ____

☐ Back Surgery: ____

☐ Neck Surgery: ____

☐ Other: ____

17) WOMEN: ARE YOU PREGNANT? ☐ YES ☐ NO ☐ NOT SURE **PATIENT'S INITIALS** ____

FAMILY HISTORY

	DIABETES	HEART	ANXIETY	KIDNEY	CANCER	DEPRESSION	BACK	OTHER CONDITIONS
MOTHER	☐	☐	☐	☐	☐	☐	☐	☐ ____
FATHER	☐	☐	☐	☐	☐	☐	☐	☐ ____
BROTHER(S)	☐	☐	☐	☐	☐	☐	☐	☐ ____
SISTER(S)	☐	☐	☐	☐	☐	☐	☐	☐ ____

List All Medications You Are Currently Taking:

	Medication	Dose		Medication	Dose
1.			9.		
2.			10.		
3.			11.		
4.			12.		
5.			13.		
6.			14.		
7.			15.		
8.			16.		

Past pain medications tried:

____

____

I ACKNOWLEDGE THAT I HAVE COMPLETED THIS QUESTIONAIRE ACCURATELLY AND TO THE BEST OF MY KNOWLEDGE.

____ PATIENT OR LEGAL GUARDIAN SIGNATURE

____ DATE

PREMIER PAIN CONSULTANTS, P.A.

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE (CONT.)

ASSIGNMENT OF BENEFITS/RIGHTS FOR DIRECT PAYMENT TO DOCTOR

PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE ASSIGNMENT FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct the ____ Insurance Company to pay by check made out and mailed directly to: Premier Pain Consultants for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay any balance of said professional service charges over and above this insurance payment, except in instances where No-Fault or Workers' Compensation insurance fee schedules apply.

I also understand and agree that I am ultimately responsible for all fees including reasonable collection costs. This assignment of benefits does not release me from my obligation to pay professional fees.

A PHOTO COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

______________________________ Name of Patient (Please Print)

______________________________ Date

______________________________ Signature of Patient

______________________________ Signature of Guardian (if Minor)

MEDICARE ASSIGNMENT OF BENEFITS/RIGHTS FOR DIRECT PAYMENT TO DOCTOR

I request that payment of authorized Medicare benefits be made on my behalf to ______________________________
Provider Name
for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

______________________________ Patient Signature

______________________________ Date

APPOINTMENT POLICY

In an effort to provide efficient treatment to all of our patients, it is the policy of this company that if you are unable to make your scheduled appointment, you must call to cancel the appointment no later than 24 hours before the scheduled time. If you fail to cancel your appointment or fail to show up to appointment, you will be charged a "NO SHOW" fee of $50.00 per occurrence. For most instances plans and Worker's Compensation carriers "NO SHOW" charges are non-covered service. You will be solely responsible for payment of this charge. Repeated "NO SHOWS" and cancellations of your scheduled appointments may result in you being DISCHARGED from care at the Premier Pain Consultants, P.A.. If you have any questions about this form, please talk to our staff before signing.

______________________________ Patient Signature

______________________________ Date

______________________________ Signature of Guardian (if Minor)

PAYMENT AUTHORIZATION

PLEASE READ CAREFULLY AND THOROUGHLY, IF YOU HAVE ANY QUESTIONS PLEASE ASK BEFORE SIGNING

Name of Patient: ________________________________ Date of Birth: ________________________

I hereby authorize medical/surgical treatment care and/or services by Premier Pain Consultants, PA, to the above named patient.

I, the undersigned, fully understand that I am primarily and financially responsible for the fees incurred by the above named patient. I further understand that the payment to said doctor is not contingent on any settlement, judgment or verdict by which the above patient may eventually recover for said medical/surgical fees. The undersigned individually obligates him/her to pay the account of the medical services in accordance with the regular rates and terms of the physician practice.

I hereby, assign, transfer, and convey payment and authorize said payment to be made directly to Premier Pain Consultants, PA, for any hospital benefits, sick benefits, injury benefits, due because of liability of a third party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for discharge or completion of all outstanding obligation related to these medical services. I further agree that this assignment **WILL NOT BE WITHDRAWN OR VOIDED** at any time until this account for this medical service is paid in full.

I understand that providing this information does not guarentee payment of any health care claim by my insurance carrier and such information is subject to change even retroactively, at any time.

I hereby authorize photocopies of this form to be valid as the original.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Premier Pain Consultants, PA, to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I certify that I have read and fully understand the above.

Signature: ____ SSN: ___________________________
(Patient, parent or guardian)

Witness: ____ Date: ___________________________

IF A PATIENT IS A MINOR (LESS THAN 18 YEARS OF AGE), A PARENT OR GUARDIAN MUST SIGN.

IT'S THE POLICY OF THIS OFFICE THAT PAYMENT IS DUE AT THE TIME OF SERVICE

2425 Babcock Rd., Ste 108, San Antonio, TX 78229
102 Palo Alto Rd., Ste. 320, San Antonio, TX 78211
18626 Hardy Oak, Ste. 215, San Antonio, TX 78258
4025 E. Southcross Bldg 3. Ste 18, San Antonio, TX 78222
(210) 616-9400

LONG-TERM CONTROLLED SUBSTANCE THERAPY AGREEMENT

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids(narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide longterm benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Our policy regarding narcotic use for CHRONIC NONMALIGNANT (non-cancerous) pain is ***strict and non-negotiable***, and is based on medical research and clinical experience. Narcotics should be used **ONLY** as a last resort and **ONLY** as an adjuvant to other therapies. The physician will provide physical resources to improve your function, as well as medical therapies and injections. Our goal is to minimize narcotic use. The rules regarding narcotic use are outlined below. These rules were developed with the patient's welfare in mind. If these rules are unacceptable or at odds with your medical goals, we will honor your request to be referred to another pain management physician.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician to consider the initial and/or continued prescription of controlled substances to treat your chronic pain. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.

1. All controlled substances must come from the physician who is assigned to your care or, during his or her absence, by the covering provider, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.) You are not to receive prescriptions for narcotic or sedative drugs from any other provider.

2. The prescribing provider has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.

3. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:
   ________________________________ phone: ________________________.

4. Unannounced urine or serum toxicology screens will be requested, and your cooperation is required. Presence of unauthorized substances may prompt termination of your opioid treatment and referral for assessment for addictive disorder.

5. Long-acting narcotics will be administered for chronic pain problems. Our goal is the discontinuation of short acting narcotics and narcotic mixtures (i.e. Percocet, Lortab, Vicodin, etc.).

6. "Rescue Doses" of short acting narcotics will not be routinely prescribed.

7. Refill will occur on a monthly basis and ONLY after a visit and physical examination. **NO REFILLS WILL BE MADE OVER THE TELEPHONE. NO REFILLS WILL BE GIVEN AFTER HOURS, ON WEEKENDS, OR HOLIDAYS. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.**

8. If refill requests are made after hours, you will instructed by the answering service to go to an emergency room of your choice.

9. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

10. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

________________________________ ________________________________

Patient's Name (Printed) Patient Signature

11. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date. Early refills will not be given.

12. Any evidence of prescriptions, forged prescriptions, substance abuse, or aberrant behavior (including verbal abuse to my office staff) will result in termination of patient-physician relationship.

13. Medications will not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc., so protect your medications. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.

14. Prescriptions are to be used **ONLY** as written. Use of increased amount of medication, without consultation with a physician, will not be allowed.

15. You may not share, sell, or otherwise permit others to have access to these medications.

16. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.

17. Original containers of medications should be brought in to each office visit.

18. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

19. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.

20. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

21. The risks and potential benefits of these therapies are explained elsewhere [and you acknowledge that you have received such explanation].

22. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.

23. Termination terms will include a written letter to you and fulfillment of your medical needs, including narcotic prescription, for one month after the date of termination. You will be presented with the option, in lieu of termination, to receive an evaluation for drug dependency and, if appropriate, be referred for detoxification.

Your pain is **YOUR** responsibility. Making appointments for medication refills is **YOUR** responsibility. Premier Pain Consultants, PA will provide medical support in your quest to minimize your pain. You must make new efforts to improve SLEEP HABITS, NUTRITION, BODY WEIGHT, CONDITIONING, AND PSYCHOLOGICAL STATE. Narcotics are not the answer to chronic pain, but can be used effectively to improve your pain.

You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

I, ____, have read and accept the conditions of this contract.

____ ________________________________

Patient Signature Date

____ ________________________________

Witness Date

Office Protocol Agreement

The following protocols are necessary to provide appropriate care to all our patients. Please review, initial each entry and sign below indicating that you understand these office protocols and agree to abide by them. Lack of signature does not invalidate these protocols.

I understand that refills are given at time of office visit. Refills are not done over the phone. ________ (initial)

I understand with controlled substance therapy (narcotics), it is expected that I may need to undergo random urine drug testing as part of my treatment plan. ________ (initial)

I understand that I am an active participant in my health care and agree to abide by the treatment plan given and reviewed with me at each visit. I understand that any changes in condition may need an office visit for reassessment. For acute changes in condition, I may need to access care through the emergency room. ________ (initial)

I understand that this practice utilizes mid level practitioners such as Physicians' Assistant and Nurse Practitioner. They provide care in terms of assessing new patients ; assessing patients on routine follow ups; assessing any changes in conditions; education of patient on condition, meds and treatment options. ________ (initial)

I understand that my access to care via telephone or on site will require my behavior to be in a manner that is not abusive to staff. I agree to refrain for behavior that reflects yelling, cursing, name calling or multiple calls in same day. I understand that this behavior may terminate my relationship with this practice. ________ (initial)

I agree to cancel my established appointments in advance to benefit other patients that are in need of earlier appointments. I understand that not showing up for an appointment without calling in advance, may be a factor in the continuation or discontinuation of my care with this group. ________ (initial)

I understand that I am to arrive 15 min before my appointment time to check in for follow ups and 45 min before a new patient appointment________ (initial)

Patients Name: ____
(please print)

Patients Signature: ____

Date: ____

Consent for Chronic Opioid Therapy

A consent form from the **American Academy of Pain Medicine**

Premier Pain Consultants PA physician may be prescribing opioid medicine, sometimes called narcotic analgesics, to me for a diagnosis that is causing me to experience pain. This decision was made because my condition is serious or other treatments have not helped my pain. 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 about the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed included: 1) Making no change to current medical regimen. 2) Discontinue current regimen completely. 3) Seeking psychological and/or psychiatric evaluation and treatment in addition to other options. 4) Initiation of physical and/or occupational therapy. 5) Seeking surgical consultation. 6) Proceeding with interventional therapy. 7) Using only non-opioid agents.

I will tell my doctor about all other medicines and treatments that I am receiving.

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 do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

I am aware that certain other medicines such as nalbuphine (Nubain ™), pentazocine (Talwin™), buprenorphine (Buprenex™), and butorphanol (Stadol™), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

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 am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

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 am aware physical dependence means that if my pain medicine 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. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain, however, it has been seen and may occur to me. 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 my doctor may check my blood to see if my testosterone level is normal.

(**Females Only**) If I plan to become pregnant or belie ve 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 have read this form or have it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines.

Patient signature ______________________________ Date______________

Witness to above ______________________________ Date______________

Approved by the AAPM Executive Committee on January 14, 1999.

PREMIER PAIN CONSULTANTS, P.A.
2425 Babcock Rd., Ste 108, San Antonio, TX 78229
102 Palo Alto Rd., Ste. 320, San Antonio, TX 78211
18626 Hardy Oak, Ste. 215, San Antonio, TX 78258
4025 E. Southcross, Bldg. 3 Ste 18, San Antonio, TX

(210) 616-9400

NOTICE OF PRIVACY PRACTICE

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.
This practice uses and disclosed health information about you for treatment. This information is used to obtain payment for treatment, administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at anytime. For more information about this notice or our privacy practices and policies, please contact our office.

Treatment, Payment, Health Care Operations
We are permitted to use and disclose your medical information to those involved in your treatment. For example: the physicians in our office are specialists. When we provide treatment we may request that your primary care and/or referring physician share your medical information with us. Also, we may provide your primary care and/or referring physician information about your condition so that he or she can appropriately treat you for the other medical conditions, if any.

Payment
We are permitted to use and disclose your medical information to bill and collect payment for services provided to you. For example, we may complete a claim form to obtain payment from your insurance carrier. The form will contain medical information such as a description of the medical service provided to you that your insurance carrier needs to approve payment to us.

Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance with regulations and the law.

Disclosures That Can Be Made Without Your Authorization
There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you may later revoke that authorization in writing to stop future uses and disclosures. However revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state or local government for the collection of information about disease, vital statistics (births & death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products that may be recalled.
We may also disclose medical information to a public agency authorized to receive reports on child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.
We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure application and inspections which are all government activities undertaken to monitor the healthcare delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or of the appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official we may disclose your medical information under the limited circumstances provided that the information:

1. is released pursuant to legal process, such as a warrant or subpoena
2. pertains to a victim of crime and you are incapacitated
3. pertains to a person who has died under circumstances that may be related to criminal conduct
4. is about a victim of crime and we are unable to obtain the person's agreement
5. is released because of a crime that has occurred on these premises or
6. Is released to locate a fugitive, missing person or suspect.

We may also release information if we believe the disclosure is necessary to prevent or relieve immediate threat to the health or safety of a person.

Workers' Compensation

We may disclose your medical information as required by the Texas worker's compensation acts.

Inmates

If you are an inmate or under the custody of law enforcement we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health, the safety of others or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, request by appropriate military command officers (if you are in the military), authorized national security and intelligence activities; as well as authorized government officials, or foreign head of state.

Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research projects and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye or tissue donation if you are a donor. Also we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such disclosure is necessary for the director to carry out his duties.

Required by Law

We may release your medical information where the disclosure is required by law.

Your Rights under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosed information or both), and (c) to whom the limits apply. Please send the request to the office and person listed below.

You may also request that we limit disclosure to family members, other relatives, or personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only reasonable requests, Please specify in your correspondence exactly how you want us to communicate with you and, if you are directly sending it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set or the information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make such review.

Texas law requires that we will be ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the lower of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. And such request must be made in writing to the person listed below. We will respond within 60 days of such request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set?
- Is not available for inspection because of an appropriate denial.
- If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know they have the incorrect information.

Accounting of Certain Disclosures

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an account to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request before any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits

We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Premier Pain Consultants
Privacy Officer
2425 Babcock Road, Suite 108
San Antonio, Texas 78229
Phone: 210-616-9400
Fax: 210-616-9402

This notice is effective on the following date: April 14, 2003.

We may change our policies and this notice at any time and have those revised policies apply all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

2425 Babcock Rd., Ste 108, San Antonio, TX 78229
102 Palo Alto Rd., Ste. 320, San Antonio, TX 78224
18626 Hardy Oak, Ste. 215, San Antonio, TX 78258
4025 E. Southcross Bldg. 3, Ste. 18, San Antonio, TX 78222
Phone: (210) 616-9400 Fax: (210) 616-9402

NOTICE OF PRIVACY PRACTICE
Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

______________________________________ ______________________________________
Signature of Patient or Personal Representative Date

______________________________________ ______________________________________
Name of Patient or Personal Representative Description of Personal Representative's Authority