100 Sara Swamy drive Suite 220 / www.shermanpain.com
Sherman Tx, 75090 Phone#903-892-1999, Fax- 903-892-6999

REGISTRATION FORM

DATE _____________

PATIENT INFORMATION

DATE OF BIRTH: ____/____/_____ (MM DD YYYY) GENDER: MALE FEMALE SOC SEC #: ______-_____-_______

FULL NAME: ____ HOME PH #: __________________
LAST FIRST MI

WORK PH #: ___________________

ADDRESS: ____

CELL PH #: ____________________

____ EMAIL:_______________________
CITY STATE ZIP

EMPLOYER's NAME: ____

MARITAL STATUS: Single Married Divorced Widowed

PRIMARY CARE PHYSICIAN:____

EMERGENCY CONTACT: ____ PH #: ____________________________
LAST FIRST MI

PREFERRED PHARMACY (name, location, phone, fax):

____

HOW DID YOU LEARN ABOUT US? ____

****

INSURANCE INFORMATION

PRIMARY INSURANCE POLICY

INS. PLAN NAME: ____ INS. GROUP # _________________________

INS. PLAN ADDRESS: _____________________________________ INS. ID # ______________________________ (Policy Number)

____ INS. PLAN PH # ________________________

____ SPECIALIST COPAY AMOUNT: ________________
CITY STATE ZIP

PRIMARY INSURED'S NAME: ______________________________________ PRIMARY'S DOB: ____/____/_____
LAST FIRST MI (MM DD YYYY)

PATIENT'S RELATIONSHIP TO PRIMARY: SELF CHILD SPOUSE OTHER________________________

****

SECONDARY INSURANCE POLICY (IF APPLICABLE)

INS. PLAN NAME: ____ INS. GROUP # _________________________

INS. PLAN ADDRESS: _____________________________________ INS. ID # ______________________________ (Policy Number)

____ INS. PLAN PH # ________________________

____ SPECIALIST COPAY AMOUNT: ________________
CITY STATE ZIP

PRIMARY INSURED'S NAME: ______________________________________ PRIMARY'S DOB: ____/____/_____
LAST FIRST MI (MM DD YYYY)

PATIENT'S RELATIONSHIP TO PRIMARY: SELF CHILD SPOUSE OTHER________________________

Patient's Printed Name__________________ Patient's Signature_______________________Date_____________

***Legal Representative's Printed Name_____________Legal Representative's Signature___________ Date______**

*If representative, specify relationship to the patient____________________________ *Note: Proof of legal authority may be required for legal representatives.* *If signing as the legal representative, I represent to that I am the legal representative of the patient and agree to provide proof of legal representation, if requested. Should my legal authority terminate, I agree to provide written notification to North Texas Comprehensive Spine And Pain Center.

Pyramid Pain & Rehab PA

1001 Sara Swamy Drive Ste 220
Sherman TX 75090-3124
Ph: 903-892-1999 Fax:903-892-6999

I authorize the following PHI to be released from the medical record of:		
Name of Patient		Date of Birth
Phone Number	Alt. Phone	
Address		
City	State	Zip Code

Release Records From To North Texas Spine & Pain
Pain Management
1001 Sara Swamy Drive Suite A
Sherman Tx 75090
Office: 903-892-1999 Fax: 903-892-6999

Release Records From To

Doctor/Facility		
Address		
City	State	Zip
Phone	Fax	

Information to be released		
Dates	From ______________	To_______________

History & Physical Exam ___________________________________
Follow Up Notes ____
Operative Reports ____
Labs____
Imaging/Diagnostic Tests ___________________________________
Nutrition Notes ____
Psychiatric Notes ____
Other____

Purpose of Disclosure:

Changing Physicians
Continuing
Care Second
Opinion
Personal Use
Insurance
School
Legal Purposes
Other ______________________________________

Your initials are required to release the following information:

____ Mental Health Records (Excluding psychotherapy notes) ____ Genetic Information (Including Genetic Test Results)

____ Drug, Alcohol, or Substance Abuse Records ____ HIV/AIDS Test Results/Treatment ____ Cancer Treatment Records

EFFECTIVE TIME PERIOD: I understand that this authorization will expire 90 days from my last date of service visit. A photocopy of this form will be considered as valid as the original. I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.
RIGHT TO REVOKE: I understand I may revoke this authorization, in writing, at any time by notifying the North Texas Spine And Pain Center/Pain Management at the address indicated below. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.
SIGNATURE AUTHORIZATION: I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. However, other state or federal laws may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment, cancer treatment, HIV/AIDS related information, and psychiatric/mental health information.

By signing below, I acknowledge that I have read and understood the authorization.

____ _______________
Signature of Patient or Legal Authorized Representative **Date**

OR

____ _______________
Signature of Parent/Legal Guardian **Date**

North Texas Comprehensive Spine & Pain Center

100 Sara Swamy drive Suite 220 / 7700 Lakeview Parkway Suite 1008
Sherman Tx, 75090 Rowlett TX 75088
Phone#903-892-1999 Fax- 903-892-6999 / Phone# 469-653-0727 Fax# 469-653-0725

INTAKE FORM

Referring Physician: _________________________ Primary Care Physician: _______________________

Please list names of other healthcare professionals that have been involved in the management of your pain:

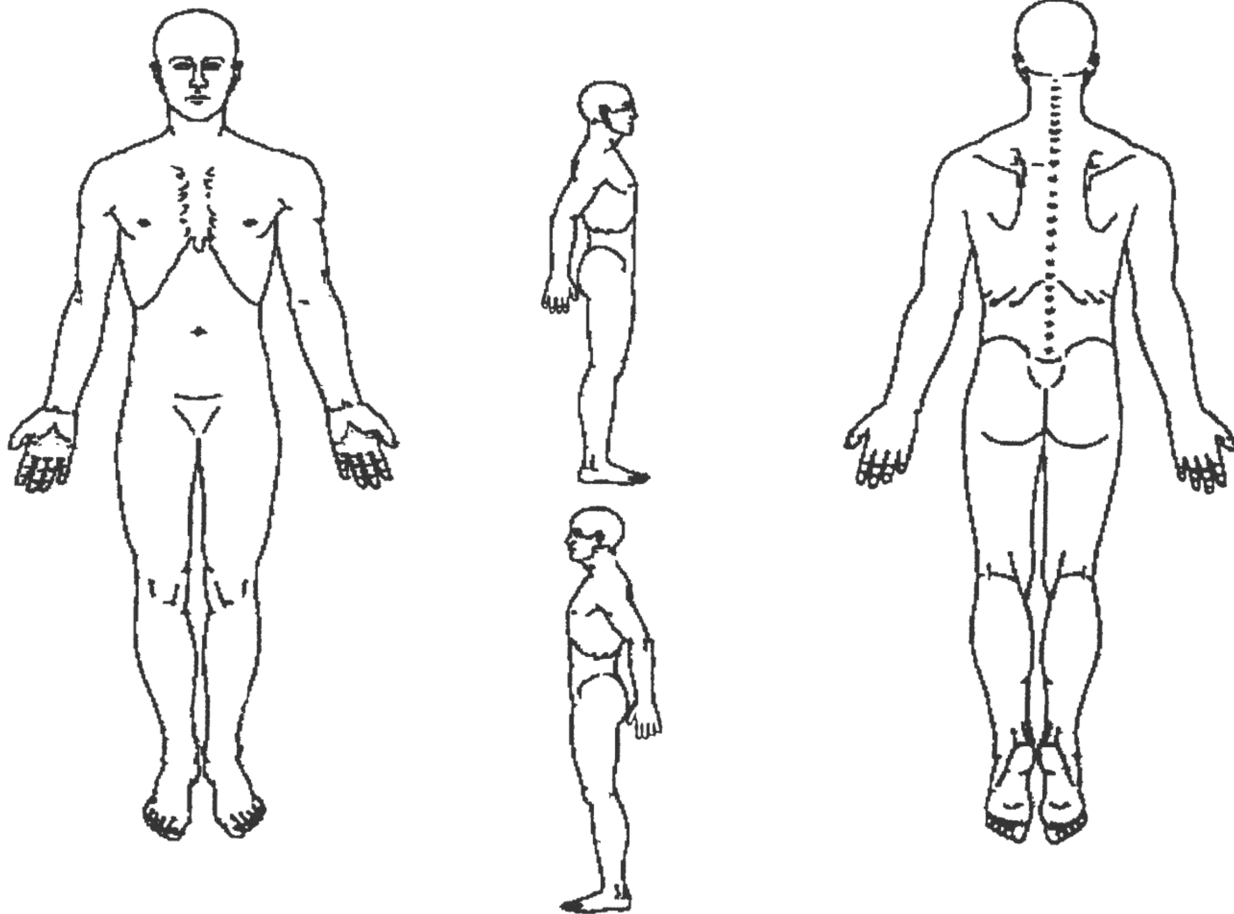
Pain Specialist: ____________________________ *Spine(orthopedic or neuro) Surgeon:* _____________________
Chiropractor: ________________________________ *Physical therapist:* ______________________________________
Neurologist: _________________________________ *Other:* ____

PAIN HISTORY

PLEASE DESCRIBE YOUR PAIN PROBLEM – Mark where your pain located – including any spreading/radiation – please state R for right, L for left or B for both if both sides are involved.

Head____ Face______ Neck_____ Mid Back ______
Shoulder _____ Arm_____ Hand_____
Chest wall_____ Abdomen_____ Pelvis_____
Lower back _____ Hip______ Buttocks_____ Thighs_____ Knee______ Calf____ Foot_____
Other____

Please use the diagram below to demonstrate where your pain is located by shading the painful areas:



100 Sara Swamy drive Suite 220 / 7700 Lakeview Parkway Suite 100B
Sherman Tx, 75090 Rowlett TX 75088
Phone#903-892-1999 Fax- 903-892-6999 / Phone# 469-653-0222 Fax# 469-653-0225

- **WHEN did your pain first begin?** ____
- **HOW did your pain begin? (Please choose one option)**
  *No particular event*_________ *After an accident*______ *Date of accident*______
  Work related? Yes ____ *No*____ *Pending litigation? Yes*_____ *No*_____
  *After surgery*_______ *Date of Surgery*________
  *Other*____
- **WHAT DOES YOUR PAIN FEEL LIKE? Please circle choices**
  - **Sharp** **Shooting**
  - **Tingling** **Cramping**
  - **Dull** **Aching**
- **HOW DOES YOUR PAIN CHANGE WITH TIME? Please circle choices**
  - **Constant**
  - **Intermittent**
- **What makes your pain BETTER?**
  ____
  ____
- **Which makes your pain WORSE?**
  ____
  ____
- **How does pain affect your lifestyle? (What can you no longer do because of your pain?)**
  ____

PAST MEDICAL HISTORY

HIGH BLOOD PRESSURE CARDIAC DISEASE PREVIOUS HEART ATTACK

COPD/ASTHMA OTHER LUNG DISEASE

ACID REFLUX STOMACH ULCERS HEPATITIS CIRRHOSIS

KIDNEY DISEASE DIABETES

STROKE SEIZURES CANCER

OTHER PROBLEMS____

SURGICAL HISTORY

Please list any operation(s) or surgeries you have had in the past:

- Type of surgery __________________Year ______ Type of surgery _______________ ____Year ________
- Type of surgery __________________Year ______ Type of surgery _______________ ____Year ________
- Type of surgery __________________Year ______ Type of surgery _______________ ____Year ________
- Type of surgery __________________Year ______ Type of surgery _______________ ____Year ________

FAMILY HISTORY

Please list any medical conditions that run in your family including chronic pain, substance use or back/neck surgeries – ____
____

North Texas Comprehensive Spine & Pain Center

100 Sara Swamy drive Suite 220 / 7700 Lakeview Parkway Suite 100B
Sherman Tx, 75090 Rowlett TX 75088
Phone#903-892-1999 Fax- 903-892-6999 / Phone# 469-653-0777 Fax# 469-653-0775

ALLERGIES:

- **Please list your ALLERGIES TO MEDICATIONS/SUBSTANCES:**

Name of Medication   Adverse Reaction Experienced   When was the last time this happened?

____

____

- **Are you allergic to Iodine Contrast Dye (e.g. IVP Dye)?** __Yes __No

If you answered yes, what type of reaction did you have and when?

____

- **Are you allergic to Aspirin or Anti-Inflammatory Medications (e.g. Ibuprofen)?**

__Yes __No If you answered yes, what type of reaction did you have?

____

CURRENT MEDICATIONS:

- Bring all current medications including prescription bottles to office visit

Please list the PAIN MEDICATIONS you currently take:

Name of Pain Medication   Dosage   How often do you take it?   Who prescribed it for you?

___________________________ ____

___________________________ ____

___________________________ ____

___________________________ ____

Please list the medications you currently take FOR OTHER MEDICAL CONDITIONS:

___________________________ ____

___________________________ ____

___________________________ ____

___________________________ ____

___________________________ ____

___________________________ ____

Please review and mark **ALL** items that have applied to you **within the last month** (including today)

GENERAL HEALTH: *Weight loss* *Weight gain* *Fatigue* *Loss of appetite*
FEMALES: *Pregnant*
EYES: *Eye pain* *Double vision*
EARS/NOSE: *Ear pain* *Hearing loss* *Ringing in ears* *Sinus Pressure*
MOUTH/THROAT: *Sore throat* *Problems Swallowing* *Hoarseness*
CHEST/HEART: *Chest pain* *Racing/pounding heart* *Problems breathing w/ lying down*
RESPIRATORY: *Cough* *Wheezing* *Shortness of breath*
GASTROINTESTINAL: *Heartburn* *Nausea/vomiting* *Diarrhea/Constipation* *Abdominal pain*
URINARY TRACT: *Blood in urine* *Increased urination* *Pain w/urination*
MUSCULOSKELETAL: *Back pain* *Pain in muscles/joints* *Stiff joints*
SKIN: *Rash* *Skin infections* *MRSA*
NEUROLOGIC: *Seizures* *Memory issues* *Weakness/numbness/tingling*
ENDOCRINE: *Increased sensitivity to cold* *Increased sensitivity to heat*
HEMATOLOGY: *Easy Bruising* *Easy Bleeding*
IMMUNE: *Frequent infections*
MENTAL HEALTH: *Anxiety/Depression* *Thoughts of hurting self or others*

100 Sara Swamy drive Suite 220 / 7700 Lakeview Parkway Suite 100B
Sherman Tx, 75090 Rowlett TX 75088
Phone#903-892-1999 Fax- 903-892-6999 / Phone# 469-653-0222 Fax# 469-653-0225

- **Do you take Aspirin?** __ Yes __ No **If you answered yes, when was your last dose?** _______________
- **Do you take blood thinners (Coumadin, Plavix, Eliquis, Pletal, Aggrenox, or Ticlid)?** __ Yes __ No
  If you answered yes, when was your last dose? _________________________
  If you answered yes, will the prescribing physician allow you to discontinue this blood thinner medication for any length of time? ___ Yes ___ No**

** Please note that you MUST have permission from the physician who prescribes or manages the blood thinner in order to stop this medication.

- **Do you take? (please circle):**
  - **Herbal medications? List** ____
  - **Vitamin E**
  - **Fish Oil**
  - **Other Supplements? List** ____

SOCIAL HISTORY

- **What is your current marital status?**
  __ *Single* __ *Married* __ *Divorced* __ *Widowed*

- **With whom do you live?**
  __ *I Live Alone*
  __ *With My Parents*
  __ *With Spouse*
  __ *With Children*
  __ *With Others (Significant Other, friends, Roommate, etc.)*

- **How far did you get in school?** ____
- **Do you currently smoke cigarettes?** ____ Yes ____ No
  If no and you are a former smoker, when did you quit for good? _____________
  If yes, packs per day? _____ For **how many years have you smoked?** __________

- **Do you currently drink alcoholic beverages?** ___ Yes ___ No
  If yes, how many drinks do you have in a week? ________

- **Have you ever been diagnosed with or treated for drug or alcohol abuse?** __ Yes __ No
  If yes, when? _______________ **Please describe** ____

- Do you currently use **illicit drugs?** ___ Yes ___ No
- Have you ever used **illicit drugs?** ___ Yes ___ No
  - If yes, what drugs and when? ____

- **Do you exercise? Y/N What kind of exercise?** ____
- **How often?** ____

WORK HISTORY

- **What is your employment status? (please check one)**
  ___ *Retired* ___ *Able to work but currently unemployed* __ *Homemaker* __ *Student*
  ___ *Not working, on Workers' Comp. leave from my job since* ___________
  ___*Working Full Time*
  ___ *Not working, on Disability since (date)* ________________
  ___ *Working Part Time*

100 Sara Swamy drive Suite 220 / 7700 Lakeview Parkway Suite 100B
Sherman Tx, 75090 Rowlett TX 75088
Phone#903-892-1999 Fax- 903-892-6999 / Phone# 469-653-0222 Fax# 469-653-0225

- **What is (was) your occupation or job title? (please describe)**
  ____
- **Please use the following space to describe any other issues related to your pain condition that has not been covered in the above questions. Your comments and concerns are welcome:**

____
____

WHICH DIAGNOSTIC STUDIES HAVE BEEN DONE TO EVALUATE YOUR PAIN PROBLEM?

- If you have had any of the imaging done please bring copies of the reports or films including EMG/NCS, MRI, CT-scan, or X-rays to office visit **(Please check all that apply)**
  Ordered by Whom?
  __ *Blood Tests* ________________________ *X-Rays* _____________________________
  __ *MRI Scan* __________________________ *CT scan* ____________________________
  __ *EMG / Nerve Conduction Studies* ________ *Bone Scan* __________________________
  __ *other?* ____________________ ____

WHICH TREATMENTS HAVE YOU DONE FOR YOUR PAIN PROBLEM?

*Injection Treatments*______________________*Chiropractor Treatments*________________________
*Acupuncture*____________________________*Surgical Treatments*____________________________
*Physical Therapy*_________________________*Psychological Treatments*_______________________
*Other*____

I certify that I have answered all of the above questions truthfully and to the best of my ability

Patient Name (Pls. Print)___________________Patient Signature________________________Date________

HIPAA/PRIVACY PRACTICES NOTICE

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.

WHAT IS THIS NOTICE? This notice tells you:

How we use and release your health information.

- Your rights concerning your health information.
- Our responsibilities to protect your health information.

TO WHOM DOES THIS NOTICE APPLY?

This notice applies to:

North Texas Comprehensive Spine and Pain Center

WHAT ARE OUR RESPONSIBILITIES TO YOU?

Your health information is personal. We are required by law to protect the privacy of your health information and will only release your health information as allowed by law or with special written permission (authorization) from you. We use the least amount of health information needed to do our work. Only those who need your health information to provide services are allowed to use it. North Texas Comprehensive Spine and Pain Center protects your information whether verbal, on paper or electronic.

WHEN IS THE NOTICE EFFECTIVE?

This notice is effective on February 1, 2010. North Texas Comprehensive Spine and Pain Center reserves the right to change this notice after the effective date. We reserve the right to make the revised notice apply for all health information that we already have about you, as well as any information we receive in the future.

HOW DO WE USE AND RELEASE YOUR HEALTH INFORMATION?

North Texas Comprehensive Spine and Pain Center has to use and release some of your health information to conduct its business. The following section explains some of the ways we are permitted to use and release health information without authorization from you.

USE AND RELEASE OF YOUR HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION:

TREATMENT PURPOSES

While we are providing you with healthcare services, we may need to share your health information with other healthcare providers or other individuals who are involved in your treatment. Examples include: doctors, hospitals, pharmacists, therapists, nurses and labs that are involved in your care.

PAYMENT PURPOSES

North Texas Comprehensive Spine and Pain Center may need to share a limited amount of health information to obtain or provide payment for the healthcare services provided to you. Examples include:

- **Eligibility -** North Texas Comprehensive Spine and Pain Center may contact the company or government program that will be paying for your health care. This helps us determine if you are eligible for benefits, and if you are responsible for paying a copayment or deductible.
- **Claims -** North Texas Comprehensive Spine and Pain Center and businesses we work with share health information for billing and payment purposes. For example, your doctor must submit a claim form to get paid, and the claim form must contain certain health information.

HEALTHCARE OPERATIONS PURPOSES

North Texas Comprehensive Spine and Pain Center may need to share your health information in the course of con-ducting healthcare business activities that are related to providing health care to you. Examples include:

- **Quality Improvement Activities -** North Texas Comprehensive Spine and Pain Center may use and release health information to improve the quality or the cost of care. This may include reviewing the treatment and services provided to you. This information may be shared with those who pay for your care, or with other agencies that review this data.
- **Health Promotion and Disease Prevention -** We may use your health information to tell you about disease prevention and healthcare options.
- **Case Management and Referral -** If you have a health problem or a healthcare need is identified by you or one of your providers, you may be referred to an organization such as a home health agency, medical equipment company or other community or government program. This may require the release of your health information to these agencies.
- **Appointment Reminders -** North Texas Comprehensive Spine and Pain Center may use your health records to remind you of recommended services, treatments or scheduled appointments.
- **Business Associates -** There are some services provided at North Texas Comprehensive Spine and Pain Center through contracts with business associates such as medical transcription services, electronic medical record, practice management company and record storage. We require business associates to protect your health information.
- **Audits -** North Texas Comprehensive Spine and Pain Center may use or release your health information to make sure that its business practices comply with the law and North Texas Comprehensive Spine and Pain Center policies. Examples include audits involving quality of care, medical bills or patient confidentiality.
- **Business Activities -** We may use or release your health information to perform internal business activities. Examples include: business planning, computer systems maintenance, legal services and customer service.

OTHER PURPOSES

- **Required By Law -** Sometimes we must report some of your health information to legal officials or authorities, such as law enforcement officials, court officials, governmental agencies or attorneys. Examples include: reporting suspected abuse or neglect, reporting domestic violence or certain physical injuries, or responding to a court order, subpoena, warrant or lawsuit request.
- **Public Health Activities -** We may be required to report your health information to authorities to help prevent or control disease, injury or disability. Examples include: reporting certain diseases, injuries, birth or death information; information of concern to the Food and Drug Administration; or information related to child abuse or neglect. We may also have to report to your employer certain work related illnesses and injuries so that your workplace can be monitored for safety.

- **Health Oversight Agencies -** We may be required to release health information to authorities so they can monitor, investigate, inspect, discipline or license those who work in the healthcare system, or for governmental benefit programs.
- **Activities Related to Death -** We may be required to release health information to coroners, medical examiners and funeral directors so they can carry out their duties related to your death. Examples include: identifying the body, determining the cause of death, or, in the case of funeral directors, carrying out funeral preparation activities.
- **Research Purposes -** At times, we may use or release health information about you for research purposes; however, all research projects require a special approval process before they begin. This process may include asking for your authorization. In some instances, your health information may be used but your identity is protected.
- **To Avoid a Serious Threat to Health or Safety -** As required by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to anyone's health or safety.
- **Military, National Security or Incarceration/Law Enforcement Custody -** We may be required to release your health information to the proper authorities so they may carry out their duties under the law. This may be the case if you are in the military or involved in national security or intelligence activities, or if you are in the custody of law-enforcement officials.
- **Worker's Compensation -** We may be required to release your health information to the appropriate persons to comply with the laws related to workers' compensation or other similar programs that provide benefits for work-related injuries or illness.

USE AND RELEASE OF YOUR HEALTH INFORMATION REQUIRING YOUR AUTHORIZATION

- **Persons Involved in Your Care -** In certain situations, we may share your health information about you to persons involved with your care, such as friends or family members. We may also give information to someone who helps pay for your care. You have the right to approve such releases, unless you are unable to function, or if there is an emergency.
- **Notification / Disaster Relief Purposes -** In certain situations, we may share your health information with the American Red Cross or another similar federal, state or local disaster relief agency, to help the agency to locate persons affected by the disaster.

WHEN IS YOUR AUTHORIZATION REQUIRED?

Except for the types of situations listed above, we must obtain your authorization for any other types of releases of your health information. If you provide us authorization to use or release health information about you, you may cancel that authorization in writing at any time. Any authorization you sign may be cancelled by following the instructions described on the authorization form.

WHAT ARE YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION?

North Texas Comprehensive Spine and Pain Center wants you to know your rights regarding your health information.

- **Right to Receive This Notice of Privacy Practices -** You have the right to receive a paper copy of this notice at any time. You may obtain a copy of the current notice by requesting us at (903)892-1999.
- **Right to Request Confidential Communications -** You have the right to ask that North Texas Comprehensive Spine and Pain Center communicate your health information to you in different ways or places. For example, you can ask that we only contact you by telephone at work, or that we only contact you by mail at home. We will do this whenever it is reasonably possible. You can find out how to make such a request by contacting the clinic manager.

- **Right to Request Restrictions -** You have the right to request restrictions or limitations on how your health information is used or released. We have the right to deny your request. You may obtain information on how to ask for a restriction on the use or release of your information by contacting the clinic manager or the privacy officer.
- **Right to Access -** With a few exceptions, you have the right to review and receive a copy of your health information. Some of the exceptions include:
    - Psychotherapy notes;
    - Information gathered for court proceedings; and
    - Any information your provider feels would cause you to commit serious harm to yourself or to others

  You can get a copy of your health information by submitting a request in writing to the Medical Record Release of Information division of our practice. This division will provide you with the necessary forms and assistance. We may charge you a fee to copy and/or mail your health record to you. If you are denied access to your health record for any reason, North Texas Comprehensive Spine and Pain Center will tell you the reasons in writing. We will also give you information about how you can file an appeal if you are not satisfied with our decision.

- **Right to Amend -** You have the right to ask that North Texas Comprehensive Spine and Pain Center **information** in your health record be changed if it is not correct or complete. You must provide the reason why you are asking for a change. You may request a change by sending a request in writing to the Medical Record Release of Information division. This division will provide you with the necessary forms and assistance. We may deny your request if:
    - We did not create the information;
    - We do not keep the information;
    - You are not allowed to see and copy the information; or
    - The information is already correct and complete.

  For release of information, please use the following phone numbers: (903)892-1999

  Right to a Record of Releases - You have the right to ask for a list of releases of your health information by sending a request in writing. Your request may not include dates earlier than the six years prior to the date of your request. If you request a record of releases more than once per year, North Texas Comprehensive Spine and Pain Center **may** charge a fee for providing the list. The list will contain only information that is required by law. This list will not include releases for treatment, payment, healthcare operations or releases that you have authorized.

WHAT CAN YOU DO IF YOU HAVE A COMPLAINT ABOUT HOW YOUR HEALTH INFORMATION IS HANDLED?

If you believe that your privacy rights have been violated, you may file a complaint with North Texas Comprehensive Spine and Pain Center or with the Secretary of Health and Human Services. To receive help in filing a complaint with North Texas Comprehensive Spine and Pain Center**,** you may contact us at (903)892-1999. You will not be denied treatment or penalized in any way if you file a complaint.

Patient's Printed Name_________________ Patient's Signature___________________Date_____________

***Legal Representative's Printed Name_____________Legal Representative's Signature___________ Date______**

*If representative, specify relationship to the patient*______________________________

**Note: Proof of legal authority may be required for legal representatives.* *If signing as the legal representative, I represent to North Texas Comprehensive Spine and Pain that I am the legal representative of the patient and agree to provide proof of legal representation, if requested. Should my legal authority terminate, I agree to provide written notification to North Texas Comprehensive Spine and Pain.

FINANCIAL POLICY

1. All co-payments, co-insurance and deductibles **must be paid at time of service** as required by the terms of our contract with your health insurance provider. Please understand that failure on our part to collect these payments can be considered insurance fraud. For your convenience we accept MasterCard, Visa, Discover, and American Express, as well as cash and check payments.
2. Please keep in mind that your health insurance policy is a contract between you and your insurance company. As a courtesy to you, we will file your claim with your insurer if you agree to have payment made directly to our practice. If your insurance company does not provide payment within 90 days we may require payment from you. If we later receive a check from your insurer, we will refund any overpayment to you.
3. Please be aware that some of the services you receive may not be covered or may be deemed not medically necessary by Medicare or other insurance companies. You will be responsible for payment of all charges for services not covered by your insurance company.
4. All patients must complete our patient registration forms before seeing the doctor. We must obtain a copy of your driver's license and insurance card. If you fail to provide us with correct insurance information in a timely manner, you may be responsible for the full amount of a claim.
5. When you schedule an appointment, that time is reserved specifically for you. We kindly ask that you provide a minimum of 24 hours notice when cancelling an appointment**. If you do not give adequate notice or fail to keep your scheduled appointment you may be charged a fee of $50.00.**
6. You will receive a billing statement from us for any balance that is owed. All amounts are due upon receipt of this statement. If it becomes necessary to turn your account over to a collection agency due to delinquency you agree to pay reasonable attorney fees or collection expenses incurred by. North Texas Comprehensive Spine and Pain. **All returned checks will be assessed a $30.00 returned check fee.**

By signing this form I acknowledge I understand and agree to the above payment policy. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. This authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this form I am responsible for payment of services in full before services are rendered.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Patient's Printed Name_________________ **Patient's Signature**___________________**Date**_____________

***Legal Representative's Printed Name**_____________**Legal Representative's Signature**___________ **Date**______

*If representative, specify relationship to the patient*______________________________

**Note: Proof of legal authority may be required for legal representatives.*

*If signing as the legal representative, I represent to North Texas Comprehensive Spine and Pain that I am the legal representative of the patient and agree to provide proof of legal representation, if requested. Should my legal authority terminate, I agree to provide written notification to North Texas Comprehensive Spine and Pain.

1001 Sara Swamy Drive Suite 220 Phone-903-892-1999 / www.shermanpain.com
Sherman Tx, 75090 Fax- 903-892-6999

INFORMED CONSENT AND PAIN MEDICATION MANAGEMENT AGREEMENT

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 fully 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 the primary pain physician **(Dr. Sreenadha Vattam),** but also the 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 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) and other medications, 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 urine drug screens 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 including birth defects.

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 automobile or other machinery while using these medications and I may be impaired during all activities, including work. If I operate machinery or automobiles and get injured or cause injury or damage to others, I am solely responsible for it and do not hold my physician who has alerted me to these possibilities.

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.

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 and reduce suffering from daily pain. 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 MEDICATION 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 communicate with my provider at every visit about my pain relief, any side-effects and improvement in quality of life.
- I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician including over the counter and other sources.
- 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. I understand that it is **against the law** to do so.
- 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 will inform my physician of a change in pharmacy immediately.
- I understand that my medication(s) may be refilled on a regular basis**. I fully understand that my medications if lost or stolen, may NOT BE REPLACED. I understand that I am required to file a police report before being considered for further treatment.**
- Refill(s) **will not be ordered before the scheduled refill date**. However, early refill(s) may be allowed by my physician when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, **I will not accept or request controlled substance medication from any other person or health care provider.** If I do so, I may be discharged from the clinic.
- 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 and/or blood tests** 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, speed, cocaine, etc**., treatment for chronic pain may be terminated**. Also, I understand that I

 1001 Sara Swamy Drive Suite 220 Phone-903-892-1999 / www.shermanpain.com
Sherman Tx, 75090 Fax- 903-892-6999

will have to comply with a consult with, or referral to, an expert: 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 understand that my physician may terminate my treatment if I am not compliant.
- 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 will not call at the end of the day or on weekends for unscheduled medication refills.

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. I have read and have been read to me the above information and all my questions were answered to my satisfaction.

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 and potential dangers 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 responsible use of these medication(s) in the treatment of my chronic pain.**

____ ____________________
Patient Signature DATE

____ ____________________
Physician Signature (or Appropriately Authorized Assistant) DATE

NAME OF PREFERRED PHARMACY ____

PHARMACY TELEPHONE NUMBER ____

PATIENT CONSENT FOR TREATMENT

Welcome to North Texas Comprehensive Spine and Pain Center**.** Please take a moment to review and sign this Consent for Treatment form.

We regret that we are unable to accept any alterations to this form and will not be able to provide health care to you if the form is not signed as presented. North Texas Comprehensive Spine and Pain Center reserves the right to make changes to this form. If changes are made, you will be presented with a new form for signature. Our clinic staff is available to answer any questions you may have.

I. Patient Rights and Responsibilities

North Texas Comprehensive Spine and Pain Center acknowledges that I have rights as a patient, and I acknowledge that I have responsibilities as a patient. These are discussed in the Patient Rights and Responsibilities and the Notice of Privacy Practices documents; copies are available to me upon request. I acknowledge being offered these documents.

II. Consent for Treatment

I, voluntarily present to North Texas Comprehensive Spine and Pain Center for medical and surgical evaluation, diagnosis, and/or treatment. I consent and authorize my provider(s) – Dr. Sreenadha Vattam or his or her designee(s) to provide diagnostic and therapeutic treatment, which may be necessary or advisable in their professional judgment. By signing this consent form, I do not waive my right to refuse recommended tests or treatment(s).

III. Payment for Services/Assignment of Benefits

I understand that, regardless of my assigned insurance benefits, I am financially responsible for payment of services rendered to me. In addition, I will be financially responsible for my spouse and my child/children that is/are born or treated by North Texas Comprehensive Spine and Pain Center or its physicians. If the providers involved in my care accept third-party reimbursement for all or part of the services I receive, I hereby agree to assign such benefits to North Texas Comprehensive Spine and Pain Center and authorize my insurance company, governmental program, or other entity to make payment directly to North Texas Comprehensive Spine and Pain Center. I understand that North Texas Comprehensive Spine and Pain Center may disclose a limited amount of health information to third-parties to obtain payment for the health care services provided. *I authorize* North Texas Comprehensive Spine and Pain Center *to communicate with any pharmacy regarding my prescription medication information including prescription history and benefits. I consent to electronic transmission of prescription information and any necessary communication with my pharmacies.*

I agree to pay co-payments, co-insurance, deductibles, and outstanding balances. North Texas Comprehensive Spine and Pain Center will honor any arrangements and/or agreements entered into with my insurance company or third-party payers. I understand that I will not be billed for amounts which North Texas Comprehensive Spine and Pain Center is contractually or legally obligated to discount. If I am injured and receive treatment at North Texas Comprehensive Spine and Pain Center,

I agree to assign to North Texas Comprehensive Spine and Pain Center my interest in any lawsuit or settlement to the extent necessary to fully pay North Texas Comprehensive Spine and Pain Center for this treatment. If my account becomes delinquent and is referred to an attorney or collection agency for collections, I agree to pay reasonable and necessary attorney's fees and collection expenses.

I certify that the information given by me in applying for payment under any medical insurance program, including Medicare and Medicaid, is correct.

Patient's Printed Name____

Patient's Signature____ **Date**____________________

***Legal Representative's Printed Name**_____________ Legal **Representative's Signature**___________ **Date**_________

*If representative, specify relationship to the patient*________________________________

**Note: Proof of legal authority may be required for legal representatives.* *If signing as the legal representative, I represent to North Texas Comprehensive Spine and Pain Center that I am the legal representative of the patient and agree to provide proof of legal representation, if requested. Should my legal authority terminate, I agree to provide written notification to North Texas Comprehensive Spine and Pain Center.

* The owners/ employees of North Texas Comprehensive Spine and Pain Center may have an ownership interest in facilities that patients are referred to for further treatment, including diagnostics and procedures. You as the patient has the right to go to any facility of your choice without any negative impact on your treatment at North Texas Comprehensive Spine and Pain Center. Please talk to our office manager if you have any question or if you would like to receive a list of alternative facilities.

NORTH TEXAS SPINE & PAIN

1001 SARA SWAMY DR. SUITE 220
SHERMAN TX,75090
PHONE: 903-892-1999 FAX: 903-892-6999

SOAPP SCORE

NAME:______________________________DATE:______________

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you!! Please answer the questions below using the follow

0 = Never 1 = seldom 2= sometimes 3= often 4 = very often

1. How often do you have mood swings? 0 1 2 3 4
2. How often do you smoke a cigarette within an hour After you wake up? 0 1 2 3 4
3. How often do you have family members, including parents And grandparents, had a problem with alcohol or drugs? 0 1 2 3 4
4. How often have others suggested that you had a drug Or alcohol or problem? 0 1 2 3 4
5. How often have any of your close friends had a problem with Alcohol or drugs? 0 1 2 3 4
6. How often have you attended AA or NA meetings? 0 1 2 3 4
7. How often have you taken medication other than the way it was prescribed? 0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem? 0 1 2 3 4
9. How often have your medication been lost or stolen? 0 1 2 3 4
10. How often have others expressed concern over your use of medication? 0 1 2 3 4
11. How often have you felt a craving for medication? 0 1 2 3 4
12. How often have you used illegal drugs(for example marijuana, cocaine,etc) in the past 5 yrs? 0 1 2 3 4
13. How often have you been asked to take urine screen for substance abuse? 0 1 2 3 4
14. How often ,in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

PLEASE INCLUDE ANY ADDITIONAL INFORMATION YOU WISH ABOUT THE ABOVE ANSWERS, THANK YOU