How did you hear about **WOL+MED**? Who Referred You?

Please tell us why you chose **WOL+MED** for your work or auto injury. Who can we thank for your referral?

☐ I saw the **sign** on the building / next to the highway.

☐ The **ER** sent me here.
____ Charlton Methodist
____ Other (Please tell us which one)_____

☐ I saw an ad in the **Yellow Pages**.
____ Verizon (IDEARC) Greater Dallas
____ AT&T Cedar Hill
____ AT&T Dallas
____ AT&T Ellis County
____ Yellow Book Ellis County
____ Yellow Book Mesquite / Garland
____ Other (Please Specify)_____

☐ A **Friend** Referred me (Please tell us who)_____

☐ A **Family** Member Referred me (Please tell us who)_____

☐ A **Co-Worker** Referred me (Please tell us who)_____

☐ A **Doctor** Referred me (Please Specify which Doctor)_____

☐ An **Attorney** Referred me (Please specify which Attorney)_____

☐ My **Employer** Referred me (Please specify which Employer)_____

☐ I saw the web site (**www.wolmed.com**) and decided to come here.

☐ I searched the internet and found **WOL+MED**.
(Which search engine did you use?)
____ Google
____ Yahoo
____ MSN
____ AOL
____ Superpages.com (from Verizon)
____ Yellow Book.com
____ Other (Please Specify)_____

☐ I was already a patient here.

☐ Other (Please Specify)_____

X X

PATIENT INFORMATION FORM

(Please **PRINT** legibly and fill in **COMPLETELY**.) Date_____/_____/_____

Last Name_____	(please give Driver's License to receptionist to copy)
First Name_____ M.I.____	Driver's License _____
Address _____	Email address _____
City _____ State_____ Zip_____	Home phone (_____)_____-_____
Employer/School_____	Work phone (_____)_____-_____
Employer Address_____	Cell # (____) ____ - _____ Fax # (____) ____ - _____
City_____ State_____ Zip_____	Date of Birth_____ Age_____
Sex ☐ Male ☐ Female	Social Security #_____-_____-_____
Person Responsible for payment ☐ Self	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
or _____	Occupation_____
	Student ☐ Yes ☐ No

⇖PLEASE FILL IN COMPLETELY⇗

Spouse's or Significant Other's Name			
Spouse's or Significant Other's Employer	Occupation (check if student)	How Long Employed	Bus. Phone
Spouse's or Significant Other's Employer's Address	City and State	Zip	Bus. Phone
Spouse's or Significant Other's Address (if different)	City and State	Zip	Home Phone
Has any member of your family been here before? (Names and ages)			
Mother's Name	Street Address, City, State, and Zip		Home Phone
Mother's Employer and Location		Occupation	Bus. Phone
Father's Name	Street Address, City, State, and Zip		Home Phone
Father's Employer and Location		Occupation	Bus. Phone
In case of emergency please notify: (other than parents, spouse, or anyone living at your residence)			Home Phone
Relationship	Street Address, City, State, and Zip		Bus. Phone
Your Hobbies:			Have you been here before? Y N What year? 19___

HOW DID YOU HEAR ABOUT US?

Saw sign
- ☐ on building/parking lot
- ☐ bowling alley

☐ newspaper

☐ emergency room
- ☐ DRMC ☐ DCH

☐ Yellow Book Denton

☐ Gainesville - SBC
☐ Verizon - Denton
☐ Verizon – Area Wide
☐ Verizon – Gainesville Complimentary

Internet/Web pages
- ☐ Google, (www.adwords.com)
- ☐ Yahoo,
- ☐ MSN
- ☐ Direct Internet Access
- ☐ Web site (www.wolmed.com)
- ☐ (www.superpages.com)

☐ friend (name)_____
☐ relative (name)_____
☐ doctor (name) _____
☐ attorney (name) _____
☐ employer (name) _____
☐ other (describe) _____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

PLEASE FILL IN COMPLETELY. PLEASE PRINT.

INSURANCE INFORMATION

If insurance information is incomplete, if deductible is not met, or if we cannot confirm insurance coverage, payment will be expected and due at time services are rendered. If your insurance company requires special forms to be filled out, it is your responsibility to complete all of the patient information and deliver the forms to us at the time services are rendered.

If you want us to bill your insurance, please...

(1) let us photocopy your current insurance card and driver's license.

(2) give us your insurance claim form supplied by your insurance company (with the patient portion filled out and signed in both places requested).

A. I assign the professional or medical expense benefit allowable and otherwise payable to me under my current insurance policy to **WOL + MED** as payment toward total charges for the 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, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original.

B. **I authorize the release of any information pertinent to my case to any insurance company, adjuster, my attorney, my employer (employer only for work related injuries), my managers, or other doctors involved in this case.**

C. I authorize release of all medical records from all other medical providers to **WOL + MED.**
FAX Medical Records to ☐ **775-599-3899 Denton**
☐ **972-572-9448 Dallas**

D. **I understand that if I do not wish to file on my insurance or if any insurance (or any other third party) does not fully cover the charges incurred, I am fully responsible for paying the balance of my account.**

E. To: Texas Workers Comp Commission or any out of state Workers Compensation Commission.
Please release any and all information regarding my case to Wol+Med Medical, P.A.

Date _____/_____/____ _____
Signature of policy holder

_____
Signature of claimant if other than policy holder

(For Office Use Only: When requesting medical records fax this form plus the patient information form)

COMPLETE HISTORY FORM (Please try to **answer** all **questions** on **both sides**. This information will **be treated as confidential.**)

Name_____ Today's Date_____/_____/_____

Date of birth_____/_____/_____ Age_____

PAST HEALTH HISTORY Month & year of last yearly physical_____/_____ ☐ Never

Have you ever had any of the following conditions? Check **"NOW"** if you have problem NOW. Check **"PAST"** if you had problem in the PAST. Check **"NEVER"** if you have NEVER HAD this problem.

	Now	Past	Never		Now	Past	Never		Now	Past	Never
Anemia/blood disease				Tuberculosis				Kidney disease			
Thyroid trouble				Pneumonia				Back pain			
Diabetes				Stomach ulcers				Epileptic seizures			
Rheumatic fever				Liver disease				Alcohol or drugs			
High blood pressure				Jaundice				Auto injury			
Heart problems				Cancer				Work injury			

List medications you take regularly?_____

What drugs are you allergic to? _____

Have you had all your "shots" (immunizations)? ☐Yes ☐No

Name and address of previous family doctor._____

Do you want to be notified when your yearly physical & blood tests are due? ☐Yes ☐No

Please list any SERIOUS illnesses, hospitalizations, cancers, or surgeries you have had.

Date	Illness or Operation	Doctor and/or Hospital

Mark X and enter Date if you have had.	
☐19___	X-rays of _____
☐ 19___	Scan of _____
☐ 19___	Colon tests
☐ 19___	Breast x-rays
☐ 19___	Heart tests
☐ 19___	Pneumonia shot
☐ 19___	Yearly physical
☐ 19___	Yearly blood tests

FAMILY HEALTH ("Blood" relations only) Check "✓" if adopted. ☐

Relative	**Names**	Age	Sex	Health Problems	If dead, cause of death	Age	Has any relation had	Yes	No
Father			M				Tuberculosis		
Mother			F				Heart disease		
Brothers & Sisters							High blood pressure		
							Alcoholism		
							Kidney disease		
							Diabetes		
							Strokes		
Children							Epilepsy		
							Nervous breakdown		
							Allergies or Asthma		
							Anemia		
							Cancer		

Please turn page! Please fill out the back of this sheet!

Check "✓" any **SERIOUS** problems you have now or have had in the past. Check **"NOW"** if you have problem NOW. Check **"PAST"** if you had problem in the PAST. Check **"NEVER"** if you have NEVER HAD this problem.

	now	past	never		now	past	never		now	past	never
Always Tired				Chills				Always Hungry			
Need Complete Yearly Physical?				Very Thirsty				Difficulty Sleeping			
Need Yearly Blood Tests?				Night Sweats				Bleeding Tendency			
Loss of Appetite				Warm "Blooded"				Growths, Tumors, Lumps			
Loss of Weight				Cold "Blooded"				Number of Alcoholic Drinks/Day			
Want Weight Loss Program?				Skin Trouble				Use/used Marijuana/Drugs			
Fever				Fainting or Dizziness				Need AIDS Test?			

HEAD & NECK	now	past	never		now	past	never		now	past	never
Allergies				Ever had Allergy Tests?				Itchy Eyes			
Headaches				Need Allergy Tests?				Frequent Colds			
Eye Trouble				Nasal Congestion				Sore Throat			
Hearing Difficulty				Nose Bleeds				Lumps in Neck			
Earaches				Congested or Runny Nose				Neck Pain			
Sinus Trouble				Sore Tongue				Sneezing Spells			

RESPIRATORY	now	past	never		now	past	never		now	past	never
Cough				Wheezing				Cigarette smoking			
Cough up phlegm				Shortness of breath				Number per day			
Cough up blood				Date of last TB test				Date of last chest x-ray			

CARDIOVASCULAR	now	past	never		now	past	never		now	past	never
Shortness of breath walking				Racing/skipping heart beat				Pains in Legs Feet (circle)			
Shortness of breath at night				Heart murmur				Poor circulation in legs			
Chest pains or pressure				Date last electrocardiogram				Cold feet, leg cramps			
High blood pressure				Swelling of ankles				Phlebitis (inflammation of veins)			

DIGESTIVE	now	past	never		now	past	never		now	past	never
Difficulty swallowing				Abdominal pain				Bloody bowel movements			
Heartburn				Gas & Bloating				Black bowel movements			
Nausea				Constipation				Do you take laxatives?			
Vomiting				Diarrhea				Any foods cause indigestion?			
Vomiting blood				Belching				Anal tags or growths			
Lump in throat				Blood on toilet paper				Hemorrhoids			

URINARY	now	past	never		now	past	never		now	past	never
Need to urinate often				Genital growths or warts				Getting up at night to urinate			
Painful urination				Wetting pants or bed				Weak urine stream			
Blood in urine				Difficulty starting urine				Have to run to the bathroom			

BONE AND JOINTS	now	past	never		now	past	never		now	past	never
Pain, stiffness, joint swelling				Have you had broken bones?				Back pain Neck pain (circle)			
Loss of joint movement				Foot trouble (warts or corns)				Do you need physical therapy?			

NERVOUS SYSTEM	now	past	never		now	past	never		now	past	never
Forgetfulness				Abnormal sensations, numbness				Difficulty walking			
Nervousness				Loss of balance				Tremors, shaking			
Depression				Clumsiness				Muscle weakness			
Frequent thoughts of suicide				Spells of any kind				Sexual difficulties of any type			
Poor concentration				Worry too much				Hot flashes			
Crying spells				Family marital problems				Irritable, feel like screaming			

SKIN	now	past	never		now	past	never		now	past	never
Warts hands feet other				Tatoos				Ingrown toe nails			
Moles				Rashes				Corns on feet			
Skin growths				Spots or veins on face				Veins on legs			

WOMEN ONLY	now	past	never		now	past	never			
Irregular menstruation				Have you passed menopause?				Number of pregnancies		
Painful menstruation				Abnormal discharge or itching				Number of miscarriages		
Very heavy periods				Do you take birth control pills?				Date of last menstrual period		
Bleeding between periods				Any trouble with breasts				Date of last yearly pap smear		
Are you pregnant?				Hysterectomy				Need wrinkle laser surgery	Yes	No

What is your main problem today?_____

What other problems do you have not listed above?_____

Doctor's signature_____

WORKER'S COMPENSATION HISTORY

Please print. Give complete answers to all questions.

Fill in if known →

TWCC # _____

CARRIER'S CLAIM # _____

Injured Employee's Name Last First Middle	Date of Birth / /	Age	Date of injury / /	Social Security Number - -
3. Employee's Mailing Address (Street or P.O. Box)			Employer's Name	
City State Zip Code	Phone No. Home ( )		Employer's Mailing Address (Street or P. O. Box)	
	Business ( )		City State Zip Code	
Supervisor's Name	Phone #		Worker's Comp Insurance Carrier	
Occupation			Date of Hire: / / Time of Accident: Rate of Pay: $____ per Hour # Hours worked/week:	

ACCIDENT INFORMATION

Give all the details of how your accident occurred._____

_____

_____

_____

_____

_____

_____

_____

Have you **reported this injury** to your employer? Yes No

Did you get checked by any **other doctor**? Yes No

Did you bring **x-ray reports**? Yes No

After the accident, **did you return to work**? Yes No

Have you ever **injured this same area** before? Yes No

Do any **other diseases or accidents** affect your work performance? Yes No

When working, do you have **to favor any part of your body**? Yes No

Have you had a **worker's compensation claim before**? Yes No

Before the injury, were you able **to work as well** as others your age? Yes No

Are your **work activities restricted** as a result of this accident? Yes No

If an **attorney** is retained, give full name and address:_____ Phone_____

In what **exact area** did you **feel pain** immediately after the accident?_____

If you **returned to work**, what was the date? Month_____ Day_____ Year_____

If you were checked by **another doctor**, give full name and address:_____

What was the doctor's **diagnosis**?_____

What **therapy**, if any, did you receive?_____

Which **x-rays** did you get? none neck back other x-rays_____

Note: If you have another treating physician, you will need to fill out a change of treating doctor's form (TWCC 53) before treatment can be started.

Do you have any other work injuries that you are being treated for? Yes No

If you have **other conditions** that **affect your work performance**, explain them:_____

Since this injury, are your **symptoms**: The **same?** **Better?** **Worse?**

HEALTH SURVEY

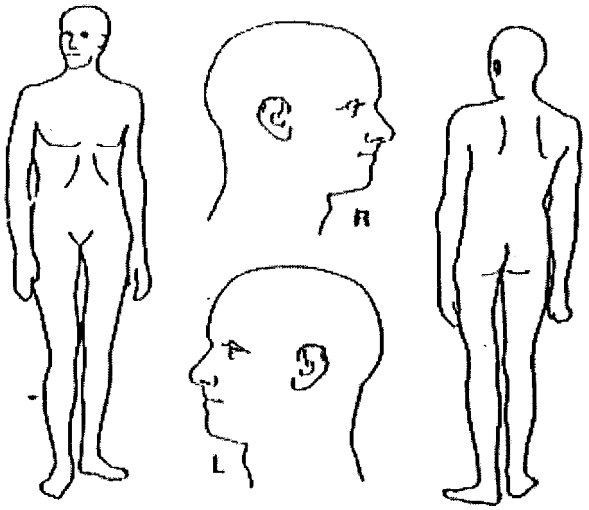
Check ✓any **SERIOUS** problems you have now or have had in the past. Check **"NOW"** if you have problem NOW. Check **"PAST"** if you had problem in the PAST. Check **"NEVER"** if you have NEVER HAD this problem.

Gastrointestinal	now	past	never		now	past	never		now	past	never
Poor appetite				Vomiting food				Abdominal pain			
Difficult chewing				Vomiting blood				Trouble controlling bowels			
Nervous System	now	past	never		now	past	never		now	past	never
Numbness				Loss of feeling				Muscle jerking			
Numbness, tingling, or weakness of feet & legs				Paralysis				Convulsions			
				Dizziness				Forgetfulness			
Numbness, tingling, or weakness of hands				Fainting				Confusion			
				Headaches				Depression			
Cardiovascular	now	past	never		now	past	never		now	past	never
Chest pain				Difficult breathing				Coughing blood			
Eye, Ear, Nose, & Throat	now	past	never		now	past	never		now	past	never
Visual problems				Nose pain				Sore gums			
Ear pain				Nose bleeding				Dental problems			
Ear noises				Nose discharge				Sore mouth			
Hearing loss				Difficult breathing thru nose				Sore throat			
Ear discharge											

Musculoskeletal	now	past	never
Low back pain			
Upper back pain			
Pain between shoulders			
Neck pain			
Shoulder pain			
Arm pain			
Knee pain			
Leg pain			
Swollen joints			
Painful joints			
Stiff joints			
Sore muscles			
Weak muscles			
Walking problems			
Need help walking			
Ruptures			
Broken bones			

Mark areas of pain resulting from this accident on figures.

Aching XXX Numbness 000 Pins & Needles === Burning ▲▲▲ Stabbing ///



Genitourinary	now	past	never
Trouble controlling bladder			
Bladder trouble			
Excessive urination			
Discolored urine			
Female	now	past	never
Breast pain			

Are you pregnant? ___ Yes ___ No

(If **"yes"**, we cannot do x-rays.)

Mark an "X" on the following scale to show how bad your pain is:

0 1 2 3 4 5 6 7 8 9 10

↑ no pain unbearable pain ↑

What are your main problems today?_____

_____

_____

Patient's signature_____ Date_____

WOL ╬ MED FINANCIAL POLICY

X X

A. NO INSURANCE

If you do not have health insurance, payment by cash, check, or credit card is required at the time of service.

B. BILLING HEALTH INSURANCE

1. If you have health insurance, we will file the claims for you if:
   a. you allow us to photocopy your insurance card and driver's license.
   b. you have completed and signed both sides of the patient information form

2. You will need to pay your copay or coinsurance at the time of services.

3. If your insurance company reduces our charges, you are responsible for the remainder after insurance payment is credited to your account. You are also responsible for payment of all "non-covered" services as indicated by your insurance company. If your insurance pays only a part of the bill, you are responsible for the remainder.

C. MEDICARE

1. We are a Medicare participating physician. We accept assignment on Medicare claims filed.
2. You are responsible for your annual deductible (currently $110.00). You have to pay the first $110.00 of allowable charges for the current year.

3. Medicare will pay our office 80% of the "allowable" charge (An "allowable charge" is the charge set by Medicare). By law, Medicare rules that we must collect 20% coinsurance from our Medicare patients.

4. Since Medicare pays 100% of the allowable charges on laboratory work, all blood tests are "free" to Medicare patients.

D. STATEMENTS

1. You will receive a statement once a month on outstanding balances. Payment is due within two weeks after receiving a statement. **It is your responsibility to notify us if your address changes.**

E. DELINQUENT ACCOUNTS

We do turn delinquent accounts over to an independent collection agency. We want to work with you to avoid this last effort to clear your account, so please notify our office of any changes of address or employment. Your best protection is to pay your copay and to pay for non-covered services at each visit so that you are never faced with an accumulation of multiple visits.

F. WORKER'S COMPENSATION

1. There is no charge to you for a verified worker's compensation injury.
2. You must bring us a photocopy of a "First Report of Injury" signed by your supervisor or have your supervisor telephone us to verify your coverage.
3. If your injury is not covered by worker's compensation, you will be responsible for payment for services.

If you have any questions, problems, or changes, please notify us. We are here to help you.
I agree to the above financial policy.
Date _____/_____/_____ _____
Signature

WOL ╬ MED
BACK AND NECK PAIN CENTER

Advance Directive:

Wol+Med Back and Neck Pain Center recognizes each individual's right to choose medical intervention. This document is to serve as your written will and intent for receiving medical intervention including CPR and appropriate resuscitation in the event of a medical emergency.

While in a cognizant and coherent mental state, I _____
Execute my right to choose or deny medical intervention/resuscitation by placing a mark in one of the following:

_____Yes, while in Wol+Med Back and Neck Pain Center, I choose to receive resuscitation and medical intervention in the event of a medical emergency. I fully understand that this intervention will potentially keep me alive with disregard to quality of life.

_____No, while in Wol+Med Back and Neck Pain Center, I choose not to receive resuscitation and medical intervention including CPR in the event of a medical emergency. I fully understand the medical consequences resulting from this decision including regards to quality of life and ultimately death.

I have executed my rights and intent for the above.

_____ _____
Signature Date

_____ _____
Witness Date

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

Notice of Our Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
Effective: 4/14/2003 (must be on or after the date of first printing or publication)

Under Federal Law, how might your protected health information need to be used/ disclosed by our office for treatment, payment, or health care operation purposes?

Generally, your protected information may be used or disclosed by our clinic for treatment, payment, or specific health care operations. These three words or phrases are defined by Federal Law, 45 CFR s 164.501 and other regulations as follows:

Treatment. *Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.*

Payment. *The activities undertaken by us to obtain or provide reimbursement for the provision of health care.* Such activities include without limit determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims; billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing; and review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges.

Other Health Care Operations. 45 CFR s 164.501 and .520(b)(1)(iii) outline several other purposes for which our practice may use or disclose protected information. For example, our practice may use or disclose protected information for the purposes of (1) conducting training programs in which student, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, (2) providing appointment reminders to patients, (3) providing treatment alternatives or other health-related benefits and services that may be of interest to patients, and (4) contacting patients to raise funds.

Disclosures to the Patient by Fax and E-mail

Periodically, patients request that our clinic transmit protected information to them by means of fax or email, or leave a message on voice mail regarding such information. While we may request specific written authorization from you prior to disclosing protected information through such means, you hereby agree (1) that by providing us with a fax number, email address, or phone number which includes voice mail, you are hereby consenting to disclosures through such means, and (2) in the even that you receive protected information from us via such means AND you do not wish to receive any more communications in these or other fashions, you agree that you will immediately instruct us in writing not to continue disclosing your protected information through such means.

Under Federal Law, how might your protected health information need to be used/ disclosed in ways that don't require written consent or authorization?

Under certain circumstances, law may require or permit our practice to make use of or to disclose your protected information without your consent or authorization. Such circumstances include:

a) Uses and disclosures required by law.
b) Uses and disclosures for public health activities.
c) Disclosures about victims of abuse, neglect, or domestic violence.
d) Uses and disclosures for health oversight activities.
e) Disclosures for judicial and administrative proceedings.
f) Disclosures for law enforcement purposes.
g) Uses and disclosures about decedents.
h) Uses and disclosures for cadaveric organ, eye or tissue donation purposes.
i) Uses and disclosures for research purposes.
j) Uses and disclosures to avert a serious threat to health or safety.

k) Uses and disclosures for specialized government functions.
l) Disclosures for workers' compensation.

What happens if other law is more restrictive than Federal Law?

In the event other law becomes more restrictive than Federal Law with respect to uses and disclosures of your protected information, our practice will include descriptions of the more stringent requirements in this privacy notice.

All other uses/ Disclosures require your written authorization

All other uses and disclosures besides those listed herein and those which require an opportunity to agree or object (see CFR 164.512) will only be made with your written authorization. Once such authorization is granted, you may revoke it at any time as provided by and subject to 45 CFR 164.508(b)(5).

Your Rights and How to Exercise Those Rights

Under Federal Law, you have the following rights. To exercise your rights, you will need to send a written request to the attention of the Privacy Officer of our clinic.

-You have the right to request restrictions on certain uses and disclosures of protected health information as provided by s 164.552(a). Please note however that under Federal Law, our clinic is not required to agree to a requested restriction.
-You have the right to receive confidential communications of protected health information as provided by and subject to 45 CFR s 164.522(b).
-You have the right to inspect and copy protected health information as provided by and subject to 45 CFR s 164.524.
-You have the right to receive an accounting of disclosures as provided by and subject to 45 CFR s 164.526.
-You have the right to receive an accounting of disclosures of protected health information as provided by and subject to 45 CFR s 164.528
-You have the right to obtain a copy of this privacy notice.

Duties of Our Clinic

Our clinic is required by law to maintain the privacy of your protected information and to provide you with notice of our legal duties and privacy practices concerning your protected information. Our clinic is required to abide by the terms of this privacy notice currently in effect. Our clinic reserves the right to change the terms of the notice and to make new notice provisions effective for all protected information that our clinic maintains. The revised notice will be made available at the front desk of our clinic for your inspection or copying.

Complaints

Our clinic welcomes any suggestions for amending our privacy practices. If you believe that your privacy rights have been violated, you may file a complaint with the Privacy Officer of our clinic and to the Secretary of Health and Human Services. To file a complaint with our Clinic's Privacy Officer, simply request and complete a copy of our privacy complaint form and submit it to our Privacy Officer. No individual may be retaliated against for filing such a complaint.

Contact Information or Further Information

For more information, call our main office number and ask to speak with our Privacy Officer.

CONTROLLED and PAIN MEDICATIONS AGREEMENT (File on top of flow sheet.)

The following agreement relates to my use of medications prescribed for pain control by

Wol+Med Clinics

I understand that taking medications in excess of or in addition to those prescribed may create a risk of harm to me, including but not limited to physical injury, addictive behavior, and a lessened effectiveness of the prescribed medication. I understand that the rules stated below are for my benefit.

I recognize that there are federal, state, and individual physician and/or clinic policies regarding the use of controlled substances or addictive medications. The Texas Intractable Pain Treatment Act, the Texas State Board of Medical Examiners, and the Texas State Board of Pharmacy all have specific requirements for the use of controlled substances and addictive medications for the treatment of chronic, intractable pain. I understand that the Physician and/or facility identified above is under no obligation to provide me with these classes of medications. I further understand that I will be provided with controlled substances and addictive medications while actively participating in this program only if I adhere to the following requirements:

1. I will use the substances only in the amount, and as prescribed and as directed by Wol+Med.
2. All controlled substances, prescription medications, or addictive medications will be prescribed only by Wol+Med. I will not use any controlled substances, prescription medications or addictive medications under any circumstances without obtaining the express permission of Wol+Med. Information that I have been receiving these substances from any other source or from "doctor shopping" may lead to a discontinuation of medications and treatment and/or discharge from this practice.
3. I agree to submit to urine and blood screens to detect the use of substances not prescribed through Wol+Med at the request of Physician.
4. I recognize that chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, and behavioral medicine strategies. I also recognize that active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program as directed by Physician to secure increased functioning and improved coping with my condition.
5. I will use only one pharmacy (name = _____) for controlled substances. I authorize Physician and/or the facility identified above to provide my pharmacist with a copy of this agreement.
6. I agree to notify Physician promptly of any other physician or other health care provider that provides me with treatment outside the scope of this program.

7. I AGREE THAT FAILURE TO FOLLOW THE ABOVE REQUIREMENTS MAY RESULT IN A DISCONTINUATION OF MEDICATIONS AND TREATMENT.

I further understand that Physician and/or the facility identified above is not responsible for medicines or treatments prescribed by other health care providers. I understand that it if appears to the physician identified above that there is no improvement in my daily function or quality of life from the medication, I may be required to gradually taper my medication as prescribed and directed by the physician. I will not hold Physician, the facility identified above or any of its employees and/or agents liable for problems caused by discontinuation of medications.

PLEASE NOTE:

1. The physician will not refill the prescription before it is due.
2. If the medication is taken in a manner other than that prescribed, the physician reserves the right to refuse to refill the prescription.
3. Medications which are lost, stolen, etc., will not be refilled early.
4. Should the patient fail to fulfill any of the above listed obligations, the doctor reserves the right not to refill the prescription.
5. Controlled or addictive medications will not be refilled after office hours, on Sundays, or on holidays. It is the responsibility of the patient to keep up with their medication and the amount remaining. The office should be notified at least three days in advance before a refill is due so the patient can be scheduled for an office visit prior to the time of running out of medication. "Emergency" narcotic or addictive medication requests are directed to the local emergency room.
6. No controlled medications will be called into the pharmacy, you must make appointment.

_____ _____/_____/_____

Patient's signature Date

_____

Witness

Name _____

Fear Avoidance Beliefs Questionnaire (Physical Activity)

Here are some of the things other patients have told us about their pain. For each statement please mark the number from 0-6 to indicate how much physical activities such as bending, lifting, walking or driving affect or would affect your back pain.

	Completely Disagree			Unsure		Completely Agree	
My pain was caused by physical activity	0	1	2	3	4	5	6
*Physical activity makes my pain worse	0	1	2	3	4	5	6
*Physical activity might harm my back	0	1	2	3	4	5	6
*I should not do physical activities which (might) make my pain worse	0	1	2	3	4	5	6
*I cannot do physical activities which (might) make my pain worse	0	1	2	3	4	5	6

FABQ(PA) Score:_____ ☐ Greater than 19 ☐ Less than 12 (For * questions only)

Fear Avoidance Beliefs Questionnaire (Work)

The following statements are about how your normal work affects or world affect your back.

	Completely Disagree			Unsure		Completely Agree	
*My pain was caused by my work or by an accident at work	0	1	2	3	4	5	6
*My work aggravated my pain	0	1	2	3	4	5	6
I have a claim for compensation for my pain	0	1	2	3	4	5	6
*My work is too heavy for me	0	1	2	3	4	5	6
*My work makes or would make my pain worse	0	1	2	3	4	5	6
*My work might harm my back	0	1	2	3	4	5	6
* I should not do my regular work with my present pain	0	1	2	3	4	5	6
I cannot do my normal work with my present pain	0	1	2	3	4	5	6
I cannot do my normal work until my pain is treated	0	1	2	3	4	5	6
*I do not think that I will be back to my normal work within 3 months	0	1	2	3	4	5	6
I do not think that I will ever be able to go back to work	0	1	2	3	4	5	6

FABQ(W) Score:_____ ☐ Greater than 34 ☐ Less than 19 (For * questions only)

Date_____ Scorer: _____
(Signature)

MEDICAL RECORDS REQUEST

☐1st Request ☐2nd Request! ☐3rd Request!!!!

☐ Denton Regional
Fax 384-4718
Phone 384-3535

☐ Presbyterian Denton
Fax 898-7280
Phone 898-7056

☐ Denton Imaging
Fax 566-1841
Phone 387-1500

☐ Lewisville
Fax 972-420-1593
Phone 972-420-1072

☐ Gainesville
Fax 940- 612-8369
Phone 940-665-1751
ext. 405

Hospital _____ Date Requested ____/____/____

Doctor _____ Date Received ____/____/____

Address _____

City, State _____ Zip _____

Area Code/phone number ____/____/____ Fax ____/____/____

YOU ARE HEREBY AUTHORIZED TO RELEASE TO:

Ed Wolski, MD, FAAFP, DAAPM
2436 I 35E South, Suite 336
Denton, Texas 76205

Phone 940-484-7000
Fax 775-599-3899

Any information, including the diagnosis and records of any treatment or examination rendered me and/or members of my family during the period listed below.

(Please Print in Big Capital Letters.) Name of Patient Date of Birth Dates Treated

1. _____ ____/____/____ ____/____/____

2. _____ ____/____/____ ____/____/____

The reason for wanting these records released is ☐ continued care ☐ transferring doctors

Please send by ☐ mail ☐ fax to 775-599-3899 (Please mail this request form back with records.)

Date Needed ____/____/____ ☐ASAP!!! **Patient signature** _____

TO BE COMPLETED BY PHYSICIAN

Please indicate below what records are needed.

☐ History and Physical
☐ Discharge summary
☐ Radiology Reports
☐ ER x-ray reports
☐CAT scans, MRIs
☐ Other scans
☐ Lab reports
☐ Pathology reports
☐ Consultation reports
☐ Operative report
☐ ER records
☐ Problem/Medication sheet
☐ Insurance and billing information
☐ Other

Telephone x-ray (scan) report (Check N if normal.)

C Spine N _____

LS Spine N _____

T Spine N _____

Other _____

_____

_____

Staff Use (Initial each step.)

_____1.Telephone for verbal report and record above.

_____2.Ask for faxed report (send to 940-383-1079).

_____3.Ask for mailed report if fax not available or medical records too extensive.

_____4.**File this form** in x-ray section of chart.

_____5.File duplicate (bottom copy) in medical records tickler file.

_____6.When faxed reports are received, remove duplicate from tickler file.

_____7.Request x-rays and medical records every 2 weeks until reports are received.