HOUSTON PAIN SPECIALISTS

New Patient Intake Information

Patient Information

Name: _____ Today's Date_____

Date of Birth: _____ Age: _____ Social Security#: _____ ❑Male ❑Female

Preferred Phone: _____ ❑Home ❑Cell ❑Work

Secondary Phone: _____ ❑Home ❑Cell ❑Work

Home Address: _____

City/State/Zip: _____

Email: _____

Physical address same as mailing address? ❑Yes ❑No - please list mailing address:

_____

Marital Status: ❑Married ❑Single ❑Divorced ❑Widowed ❑Other

Race: ❑American Indian or Alaskan Native ❑Asian or Pacific Islander ❑Black or African American

❑Native Hawaiian or Other Pacific Islander ❑White ❑Hispanic ❑Non-Hispanic ❑Refuse to Report

Primary Language: ❑English ❑Spanish ❑Other: _____

Primary Insurance Plan

Insurance Name (ex: Medicare/ BCBS/ Aetna/ UHC/ Cigna/ Humana): _____

Plan: _____ Policy/ID #: _____ Group #: _____

*Complete this if you are **NOT** the policy holder for your primary insurance*

Policy Holder: ❑Spouse ❑Child ❑Other: _____

Policy Holder Name: _____ Phone: _____

Date of Birth: _____ Social Security #: _____ ❑Male ❑Female

Secondary Insurance Plan (if any)

Insurance Name (ex: BCBS/ Aetna/ UHC/ Cigna/ Humana): _____

Plan: _____ Policy/ID #: _____ Group #: _____

*Complete this if you are **NOT** the policy holder for your primary insurance*

Policy Holder: ❑Spouse ❑Child ❑Other: _____

Policy Holder Name: _____ Phone: _____

Date of Birth: _____ Social Security #: _____ ❑Male ❑Female

Referral Information

HOUSTON PAIN SPECIALISTS

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

How did you find us? ❑Physician ❑Insurance ❑Family ❑Friend ❑Website ❑Other: _____

Preferred Pharmacy

Pharmacy Name: _____ Phone: _____

Street Address: _____ City/State/Zip: _____

Emergency Contact/Authorized HIPAA Contact Information

Emergency Contact Name: _____

Phone: _____ Relationship to Patient: _____

Worker's Compensation, Motor Vehicle or Injury Claim Information

Is your pain the result of a Worker's Compensation Injury? ❑Yes ❑No

Workers Comp Company: _____ Claim #: _____

Agent Name: _____ State of Injury: _____ Date of Injury: _____

Phone: _____ Fax: _____

Is your pain the result of a Motor Vehicle Accident or Personal Injury? (legal term describing injury sustained to your person by negligence of another) ❑Yes ❑No If yes, you will be asked to complete a separate form

General Consent and Authorization for Treatment, Evaluation, and Information Release

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time. I certify that my Medical History is complete and accurate to the best of my knowledge and ability.

I voluntarily request that Houston Pain Specialists, PLLC (hereafter referred to as the "Practice") provide pain management care, anesthesia, treatment, and services to me, as deemed reasonable and necessary by the assigned healthcare provider(s). I consent to reasonable and necessary medical examination, evaluation, testing and treatment which may include diagnostic, radiology and laboratory procedures. I understand I may be asked to provide urine, oral swab, and/or blood samples. I have the right to refuse specific tests, but understand this may impact my treatment. If invasive interventional treatment is recommended, I will be informed of the benefits and risk prior to performance of such treatment and will be provided with a separate consent form outlining such benefits and risk.

RELEASE OF INFORMATION I specifically authorize the uses and disclosures of my health information as described in the Notice of Privacy Practices provided to me. I authorize the Practice to obtain and share my medication history and other relevant health care information, verbally, written or electronically, that is deemed necessary for my treatment. I consent to release of my health information to federal or state health plans, insurance companies, collection agencies, employers or other organizations responsible for payment of services, as appropriate. I understand that this may include information relating to my diagnosis, care, payment for my care, or demographic information.

BY SIGNING BELOW, I AM AGREEING TO THE CONSENTS AND RELEASES DESCRIBED ON THIS FORM. I HAVE READ THIS CONSENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

_____ _____

Printed Name of Patient or Representative | Signature of Patient or Representative

_____ _____

Relationship to Patient | Date

HOUSTON PAIN SPECIALISTS

NEW PATIENT PAIN ASSESSMENT FORM

Patient Name: _____ DOB: _____ Age: _____

Welcome to our office. Our goal is to provide you with the best possible medical care in a timely manner. Please help us by completing this questionnaire:

MEDICAL HISTORY (check all that apply):

_____AIDS
_____Attention Deficit
_____Anemia
_____Anxiety
_____Asthma
_____Bleeding Disorder
_____Cancer: _____
_____Cholesterol – **High/Low**
_____Chronic Back Pain
_____Congestive Heart Failure
_____Coronary Artery Disease
_____Depression
_____Diabetes
_____Diverticulitis
_____Emphysema
_____GI Bleed
_____Gout
_____Heart Attack
_____Hepatitis – **A / B / C**
_____High Blood Pressure
_____HIV
_____**Hyper/Hypo** Thyroid
_____Irregular Heart Beat
_____ Irritable Bowel Syndrome
_____Kidney Failure
_____Liver Problems
_____Lupus
_____Migraines
_____Neurological Disorder
_____Poor Circulation
_____Pulmonary Embolism
_____Reflux
_____Rheumatoid Arthritis
_____Seizures
_____Sexual Dysfunction
_____Skin Rash/Ulcers/Lesions
_____Sleep Apnea
_____Stroke
_____Meningitis
_____**OTHER** _____
_____**NONE**

SURGICAL HISTORY

1. Have you had spinal surgeries? □ CERVICAL (Neck) □ THORACIC (Mid-Back) □ LUMBAR (Low Back)
   If so, what type? _____
2. Have you had Facet/Epidural Steroid Injections? □ CERVICAL(Neck) □ THORACIC(Mid-Back) □ LUMBAR
   If so, last injection date? _____
3. Do you have a **STENT, PACEMAKER, PORT** or any other **implantable device**? □ Yes □ No
   If so, what type?_____

ALL OTHER SURGERIES (check all that apply):

_____Abdominal Surgery
_____Amputation
_____AV Fistula Creation
_____AV Graft
_____Aortic Valve Replacement
_____Appendectomy
_____Beast Surgery
_____Bronchoscopy
_____CABG
_____Carotid Endarterectomy
_____Carpal Tunnel
_____Cataract Extraction
_____Cholecystectomy
_____Colon Resection
_____Craniotomy
_____Gastric Bypass
_____Hemorrhoidectomy
_____Hip Replacement
_____Knee Arthroscopy
_____Knee Replacement
_____Kyphoplasty
_____Lumpectomy
_____Mastectomy
_____Mitral Valve Replacement
_____Nephrectomy Native
_____Para Thyroidectomy
_____Pneumonectomy
_____Prostatectomy
_____PTCA
_____RA-F Bypass
_____Rotator Cuff Repair
_____TURP+
_____TAH w/ BSO
_____Hysterectomy
_____Tonsillectomy
_____Tunneled Dialysis Catheter
_____UPPP
_____Vertebroplasty
_____**OTHER:**_____

Anesthesia Problems: □ Yes □ No
Surgical Complications: □ Yes □ No
Post-OP Complications: □ Yes □ No

HOUSTON PAIN SPECIALISTS

FAMILY HISTORY (check all that apply):

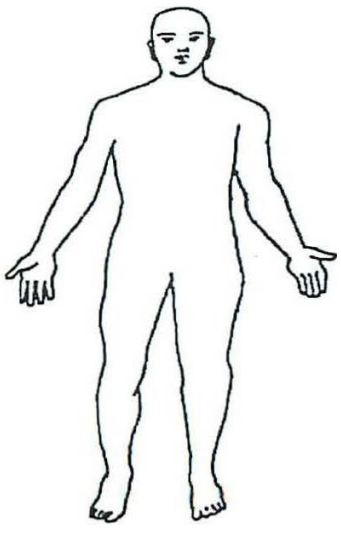
_____Alcoholism
_____Anemia
_____Angina
_____Arthritis
_____Anesthesia Complications
_____Anxiety
_____Asthma
_____Birth Defects
_____Blood Clots
_____Blood Transfusions
_____Bowel Disease
_____Cancer: _____
_____Cholesterol **High/Low**
_____Depression
_____Diabetes
_____Growth Development
_____Headaches
_____Heart Disease
_____Hypertension
_____Liver Disease
_____Melanoma
_____Migraines
_____Osteoporosis
_____Psychiatric Care
_____Seizures
_____Severe Allergies
_____Stroke
_____Suicide Attempt
_____Thyroid Disease
_____Weight Disorder

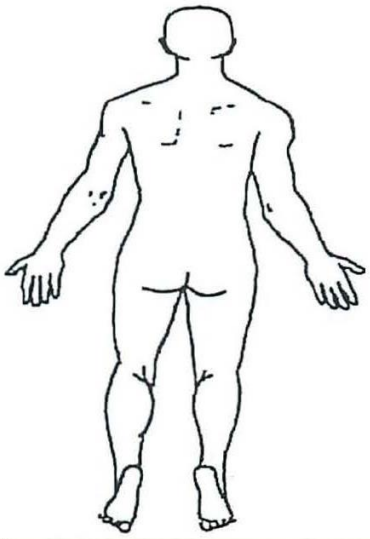
PAIN HISTORY:

1. What is your chief complaint for todays visit? _____
   _____
2. How did the problem begin?: □ WORK □ INJURY □ MOTOR VEHICLE ACCIDENT □ OTHER
   Brief explanation: _____
3. How often do you have pain and how long does it last?_____
4. Pain is worse WHEN I?_____
5. Pain is better WHEN I?_____
6. Difficulty sleeping? □ YES □ N0
7. Problems with daily activities (personal hygiene, house keeping, walking, grocery shopping, etc)? □ YES □ N0
8. On a scale of 0 to 10 (0=pain free and 10=very painful), pain level right now? _____
9. How would you describe your pain? □ Dull □ Aching □ Throbbing □ Sharp □ Burning
10. Please check below all that applies and write body part:
    □ Numbness - Where? _____
    □ Tingling - Where? _____
    □ Weakness - Where? _____
    □ Coldness - Where? _____
    □ Muscle Spasms/Cramps - Where? _____
    □ Changes on Skin Color - Where? _____

CURRENT PAIN DETAILS

Please use the following symbols to fill in the diagram below:





N = Numbness
\+ = Sharp
* = Burning
Δ = Aching
// = Pins & Needles
• =Shooting
○= Other:_____

Answer the following by circling a number from 0 (no pain) to 10 (worse pain imaginable):

What is your *Current* pain score (0-10):
0 1 2 3 4 5 6 7 8 9 10

What is your *Average* pain score (0-10):
0 1 2 3 4 5 6 7 8 9 10

HOUSTON PAIN SPECIALISTS

PAIN TREATMENT HISTORY:

1. First medical care date for current problem? _____
2. Please list the names of all doctors you have seen for **this** condition:
   - Doctor _____ Specialty_____ Phone _____
   - Doctor _____ Specialty_____ Phone _____
   - Doctor _____ Specialty_____ Phone _____
   - Doctor _____ Specialty_____ Phone _____
   - Doctor _____ Specialty_____ Phone _____
3. What studies were done?
   □ EMG Physician: _____ Most recent date _____
   □ MRI Most recent date _____
   □ CT scan/Myelogram Most recent date _____
   □ X-RAY Most recent date _____
   □ DEXA SCAN Most recent date _____
4. Treatments performed:
   □ Physical Therapy (circle) US, Ten Unit, Massage, Core Strengthening
   □ Exercise Program Relief? _____
   □ Chiropractic Manipulation How long? _____
   □ Injections IN office _____ OutPatient Procedure _____
   □ Psychotherapy/Counseling Results _____
5. **Allergies** to medication? □ No □ Yes - Please List: _____
   _____
6. Allergies other than medications? □ No □ Yes - Please List: _____
7. Please list all of the medications including any over the counter medications, diet supplements, blood thinning medications (Asa, Ecotrin), all herbal (Mai huang, St John's wart), and NSAIDS (Motrin, Ibuprofen, Aleve) medications:

PLEASE LIST ALL INFORMATION REQUESTED

Medication	Doseage	Frequency	Prescribing Physician

- Please be advised, if you have any heart conditions or if you are on Plavix, Coumadin,etc, we will require a written approval from your prescribing physician for discontinuation of these medications prior to scheduling any procedures.
- Please be advised, if you are a diabetic, your blood sugar may increase following steroid injections. Please also note that you need to monitor your blood sugar closely following procedures, and may need assistance at home for 24 hours after injections. Contact your prescribing physcian prior to your procedure for specific instructions.

8. Height _____ Weight _____
9. Have you been **prescribed or use any type of OXYGEN** in the past 12 months? If so, explain usage: _____
10. Have you ever seen a psychologist or psychiatrist? □ Yes □ No

HOUSTON PAIN SPECIALISTS

11. Do you smoke? □ Yes □ No How may cigarettes per day? _____
12. If you are a former smoker, when did you quit? _____
13. Do you drink alcohol? □ Yes □ No
14. Do you use recreational drugs? □ Yes □ No
15. Have you ever had a problem with substance abuse? □ Yes □ No
16. Are you currently working? □ Yes □ No If not, why? _____
17. Please, briefly describe your job duties: _____

Patient Name: _____ DOB: _____

REVIEW OF SYSTEMS (check all that applyto you NOW)

GENERAL	EYES	EARS, NOSE, THROAT	CARDIOVASCULAR	RESPIRATORY
□ fever	□ blurring	□ earache	□ chest pains	□ cough
□ chills	□ diplopia (double vision)	□ ear discharge	□ palpitations	□ dyspnea (difficulty breathing)
□ sweats	□ irritation	□ tinnitus	□ syncope (fainting)	□ excessive sputum
□ anorexia	□ discharge	□ decreased hearing	□ dyspnea on exertion (difficulty breathing)	□ hemoptysis (coughing up blood)
□ fatigue / weakness	□ vision loss	□ nasal congestion	□ orthopnea (difficulty breathing lying flat)	□ wheezing
□ malaise (discomfort)	□ eye pain	□ nosebleeds	□ PND (Paroxysmal Nocturnal Dyspnoea)	□ pleurisy
□ weight loss	□ photophobia	□ sore throat	□ peripheral edema	
□ weight gain		□ hoarseness		
□ sleep disorder				

GASTROINTESTINAL	GENITOURINARY	MUSCULOSKELETAL	DERM / SKIN	NEUROLOGICAL
□ nausea	□ dysuria (painful urinating)	□ back pain	□ rash	□ paralysis
□ vomiting	□ hematuria (blood in urine)	□ neck pain	□ itching	□ paresthesias (burning or prickling in hands, arms, legs, feet, etc)
□ diarrhea	□ discharge	□ joint pain	□ dryness	□ seizures
□ constipation	□ urinary frequency	□ joint swelling	□ suspicious lesions	□ tremors
□ change in bowel habits	□ urinary hesitancy	□ muscle cramps		□ vertigo
□ abdominal pain	□ nocturia (excessive urination at night)	□ muscle weakness		□ transient blindness
□ melena (black, tarry stools)	□ incontinence	□ stiffness		□ frequent falls
□ hematochezia (vomiting of blood)	□ genital sores	□ arthritis		□ frequent headaches
□ jaundice	□ decreased libido	□ sciatica		□ difficulty walking
□ gas / bloating	□ erectile dysfunction	□ restless legs		
□ indigestion / heartburn		□ leg pain at night		
□ dysphagia (difficulty swallowing)		□ leg pain with exertion		
□ odynophagia (painful swallowing)				

PSYCHOLOGICAL	ENDOCRINE	HEMATOLOGICAL/LYMPHATIC	ALLERGY / IMMUN
□ depression □ anxiety □ memory loss □ suicidal ideation □ hallucinations □ paranoia □ phobia □ confusion	□ cold intolerance □ heat intolerance □ polydipsia (excessive thirst) □ polyphagia (excessive hunger) □ polyuria (excessive amount of urine production) □ unusual weight change	□ abnormal bruising □ bleeding □ enlarged lymph nodes	□ urticarial (hives) □ allergic rash □ hay fever □ recurrent infections

Patient Name: _____ Date: ____/_____/_____

Please answer each question as honestly as possible by putting the corresponding number in the box to the right (ie, if "Seldom" write "1", if "Sometimes" write "2", etc). There are no right or wrong answers.

SCORE	COLOR	Initials of Reviewer

SOAPP®-R

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?					
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you can't handle them?					
5. How often is there tension in your home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medications from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					
Has any relative had a problem with: **(Please circle Y/N for each item below)** Alcohol: Y/N Addiction: Y/N Mental Illness: Y/N					

Green = less than 9	***Yellow = 10-21***	***Red = 22 and over***

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

Northwest Anesthesiology and Pain Services, PA

Urine Toxicology Testing Protocol

- ***All*** visits which a controlled substance is indicated will require a Urine Drug ***Screen*** conducted and reviewed prior to prescribing.
- Urine Drug ***Confirmation*** will be conducted based on the results of the SOAPP-R Questionnaire, given on the initial visit and every 3 months after. The Confirmation will be reviewed with the patient at the next visit and guide the provider on future controlled substance prescriptions.
- Initial visit will have a Urine Drug Screen and Urine Drug Confirmation.
- Patients not taking opioids will be tested every 6 months, for quality assurance in treatment (including the initial visit).

SOAPP-R Results/Groups

Red

-Urine Confirmation
-Sent for confirmation on every visit
-Reviewed with patient at the following visit
-Documenting normal/abnormal results
-Conducted until SOAPP-R score re-categorizes patient into yellow or green groups

Yellow

-Urine Confirmation
-Sent for confirmation every 3 months
-Reviewed with patient at the following visit
-Documenting normal/abnormal results
-Conducted until SOAPP-R score re-categorizes patient into red or green groups

Green

-Urine Confirmation
-Sent for confirmation every 6 months
-Reviewed with the patient at the following visit
-Documenting the normal/abnormal results
-Conducted until SOAPP-R score re-categorizes patient into red or yellow groups

Patient Signature of Acceptance of protocols:_____ Date: _____

Northwest Anesthesiology and Pain Services, PA

HOUSTON PAIN SPECIALISTS

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
Medical Records Release/Request Form

Patient Name: _____
(Last, First, Middle Initial) (Previous Name)

Address: _____
(Street or PO Box) (City/State) (Zip)

Date of Birth:_____**Telephone:**_____**Social Security# xxx-xx-**_____

Reason of Record Request:

□ Continuation of Care	□ Billing or Claims	□ Disability Determination	□ Other
□ Transferring Care	□ Insurance	□ School	_____
□ Personal Use	□ Legal Purposes	□ Employment	

I hereby authorize **HOUSTON PAIN SPECIALISTS** to **RELEASE MY HEALTH INFORMATION TO:**

_____
(Person or Organization)

_____
(Street Address or PO Box)

_____
(City, State, Zip)

_____ _____
(Telephone Number) (Fax Number)

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want released/disclosed. If all health information is to be released/disclosed, then check ONLY the first box**.**

□ Complete Medical Record - ALL	□ Operative Reports
□ Last 6 Months Records of Active Treatment	□ Psychological Records **SEE BELOW**
□ Office Visits (From_____to_____)	□ Physician Orders
□ Imaging Reports	□ Other (specify) _____
□ Lab Results	

YOUR INITIALS ARE REQUIRED TO RELEASE THE FOLLOWING:
_____ I do___(OR) do not___consent to release information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol/drug abuse and/or HIV testing/results, or such disclosure shall be limited to the following specific types of information: _____.

EFFECTIVE TIME PERIOD: This authorization expires within (6) months from the date signed. If you wish to have the authorization expire before (6) months, please indicate the date of expiration:_____.
RIGHT TO REVOKE: I understand that I can withdrawal my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named as the RECEIPENT of the medical records and to Houston Pain Specialists I understand that prior actions taken in reliance on the authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. It is further understood that the information is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____
(Signature of Patient or Legal Representative*) (Date)
**Legal Representative must submit copies of a legal document supporting assignment of this authority.*

Houston Pain Specialists 5420 Dashwood Dr, Suite 103, Houston, TX 77081

Ph: (713)-664-2662 Fax: (713) 987-7691

HOUSTON PAIN SPECIALISTS

HIPAA DISCLOSURE:
PATIENT CONTACT & VERBAL RELEASE OF INFO CONSENTS

Patient Name (*print)*: _____ DOB: _____

A) RELEASE OF PATIENT INFORMATION CONSENT

Consent to Verbally Release

I hereby give consent to release my personal health information either verbally or in writing to my family, friends, or others for purposes of obtaining treatment and/or for payment of medical services.

In that regard, Northwest Anesthesiology and Pain Services, PA and Houston Pain Specialists, have my permission to release my confidential personal health information to the following family members, friends, or other individuals who are involved in my care:

Name	**Relationship to Patient**
_____	_____
_____	_____
_____	_____

I understand that I have the right to revoke this authorization, at any time by providing written notice to this office. The revocation will take place on the date of the written notice and cannot be applied to prior disclosures.

A) AUTHORIZATION TO COMMUNICATE/LEAVE MESSAGES

From time to time it may be necessary for representatives of Northwest Anesthesiology and Pain Services, PA to leave messages for patients on their home or cellular phone. The purpose of these messages may be to return patient calls, remind patients that they have an appointment, to notify patients that the medical staff would like to discuss lab or procedure results, or to ask a patient to call one of the clinics of Northwest Anesthesiology and Pain Services, PA regarding an issue or concern. At no time will a representative of Northwest Anesthesiology and Pain Services, PA discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with your household members, your answering machine and/or on your voicemail. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Initial: _____ Consent to leave message with HOUSEHOLD MEMBERS (at phone numbers you have provided in record)

Initial: _____ Consent to leave message on HOME ANSWERING MACHINE (to phone numbers you have provided in record)

Initial: _____ Consent to leave message on VOICEMAIL and/or TEXT MESSAGING/SMS (to phone numbers you have provided in record)

_____ _____

Patient Signature Date

Houston Pain Specialists
5420 Dashwood Drive, Suite 103
Bellaire, TX 77081
T (713) 664-2662
F (713) 987-7691

Northwest Anesthesiology and Pain Services, PA

Northwest Anesthesiology and Pain Services, PA

HOUSTON PAIN SPECIALISTS

Code of Conduct

We are glad that you have chosen Houston Pain Specialists as your new pain management provider. We strive to improve your quality of life through medication management and Interventional pain therapies.

Listed below are reasons our group may consider as grounds for patient termination from the practice. This are inclusive, but not limited to the following:

- ✓ Disruptive, uncooperative, or disrespectful behavior towards our staff either in-person or via telephone conversation (Please Note: this will include relatives and non-relatives of the patient)
- ✓ Repeated No Shows, Cancellations, and Late arrivals. Patients are required to provide notification to office staff 24-hours prior to the scheduled appointment of any reason they are not able to keep the original appointment date or time.
- ✓ Refusing to adhere to your provider's plan of care
- ✓ Violating your medication and controlled substances agreement.
- ✓ Failure to pay for services rendered. (Please Note: for any questions regarding outstanding balances, call the billing department at 832-698-5320 for assistance.)
- ✓ You, the patient, terminates the relationship with a provider of Northwest Anesthesiology and Pain Services, PA.

Message Regarding Social Media Reviews/Postings:

You have the right to publish reviews via social media (Facebook, Yelp, Google, etc…) regarding your experience with Northwest Anesthesiology and Pain Services, PA and its providers. However, if a negative review is published before allowing us to rectify or resolve the situation, you grant us permission to review and/or request the negative comment to be removed from the site.

Violation of these policies may be considered for patient termination at your provider's discretion.

Printed Name: _____ Date: _____

Signature: _____

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Northwest Anesthesiology and Pain Services, PA

Medication History Consent Form

Name:	DOB:	Date:

On behalf of Northwest Anesthesiology & Pain Services, PA my provider: _____ has educated me regarding medication that has been prescribed to me regarding the benefits and possible side effects of this medication, possible drug, and/or food interactions that may occur while taking this medication, and the possible effects of this medication if the person taking this medication becomes pregnant. I have also been informed of the reason or purpose for which this medication was prescribed.

I also provide consent to my prescriber to have access to my past prescription history.

Patient Signature: _____ Date: _____

- It is recommended that women who are or may become pregnant, or are breast-feeding, discuss this with their doctor **BEFORE** taking any medication.
- It is recommended that patients be educated on reporting all side effects they experience, including, but not limited to, which side effects to report **IMMEDIATELY** to a health care provider
- It is recommended that any provider prescribing medications to obtain a thorough patient history that should include (but not limited to):
    1. What medication including prescribed over-the-counter medications, the patient is or has been taking
    2. What food and drug allergies the patient has
    3. What medical conditions the patient has
- Patient (or guardian) has verbalized understanding of medication education

Northwest Anesthesiology and Pain Services, PA

MEDICATION/OPIOID CONTRACT

I, _____, agree to the following guidelines as part of my treatment for chronic pain management with a provider from Northwest Anesthesiology & Pain Services, PA.

1. I understand the following:
   - If I have a chronic pain problem, it may require the prescription of opioid pain medications to increase my quality of life by increasing my function and reducing my pain perception. I understand that Opioid medications can also be prescribe for short term, temporary, acute pain problems. The risks, side effects, and benefits of the medication have been discussed with me in detail in the event that chronic opioid therapy is indicated. I agree to the policies set forth by Northwest Anesthesiology and Pain Services, PA in accordance to the federal and state guidelines, for toxicology monitoring and diagnostic testing needed to evaluate the risks associated with opioid treatment.
   - I understand that the use of the opioids in pain Management is an acceptable practice, however, there is a potential for habit formation and in some instances, may result in addiction.
   - If I am treated with opioid medications, I agree to take the medications only as prescribed and I will not accept a prescription for an opioid based, controlled substance, from another physician, without approval from my provider. An exception to this would be in an emergency situation, where I will notify the ER Providers of my opioid contract with Northwest Anesthesiology and Pain Services, PA.
   - I will use only one pharmacy to obtain prescribed controlled substances and any changes to this must be discussed with the provider prior to any changes. The pharmacy will be in the greater Houston area associated with the office I am being treated in, not out of the state of Texas. I give full consent for my provider and pharmacist to exchange information in writing or verbally. I also understand that changing pharmacies regularly is considered by the state and federal government as high risk behavior for drug aberrancy and I will comply with the office policy for toxicology testing when doing so.
   - I understand that opioids are not effective long term, as single therapy, due to tolerance and dependency. An opioid prescription will be used in conjuncture a with multi-modal therapeutic plan, focused on interventional treatment options. If I am prescribed opioids, the goal is to continuously reduce and/or taper me off of them. To do so, I will meet the provider regularly to assess my progress. If the provider does not feel that opioid therapy is medically indicated, then they are not obligated to continue prescribing them.This may meanprocedures, intervention, and even surgery will be considered and expected as the appropriatetreatment over opioid medication(s).
   - I am responsible for any lost, misplaced, stolen or miscounted medications from the pharmacy. The provider will not replace my medications or refill my medications early in the event that this occurs. I will not share my medications with anyone. A stolen medication will require a police report to be made and a notification to my provider within 48 hours of loss.
   - I agree to participate in any medical or psychological assessments recommended by my provider for assessment for dependency, aberrancy or worsening of any comorbid conditions. I also understand that I will comply with Urine Drug Testing Policies of the office, including random sampling and pill counts. Failure to show up at the allocated time for random testing would forfeit my next prescription.
   - The use of illegal drugs can lead to immediate discontinuation of opioid therapy and possible dismissal from the practice, at the discretion of the provider and practice. If toxicology testing is indicated, I will follow the protocols for toxicology testing as well as be responsible for any financial costs, if not covered by my insurance.
   - I understand that at every visit I will bring all prescription medications with me in their original containers on every appointment even if the bottle is empty. Failure may result in the rescheduling of my appointment.
   - Failure to comply with ordered procedures or test may result in the discontinuation of medications.
   - Based on the opioid medication taken, the amount, and the "time on these medications," the physicianwill determine the time interval for refills and re-evaluation based on state guidelines. Evaluation canonly be seen 7 days prior to the medication historical refill date. Most pharmacies will only refill 5 days"earlier" to this date. Refills are processed 30-31 days since the last refill date; not from the last dayseen by the physician. Lastly, it is not the physician's responsibility to refill your prescription if you are"out of town" or "on vacation"

2. I understand that my provider may stop prescribing the medications listed if:
   - I do not show any improvement in pain or my activity has not improved.
   - I develop rapid tolerance or loss of improvement from the treatment.
   - I develop significant side effects from the medication.
   - The clinic finds that I have broken any part of this agreement.
   - My toxicology diagnostic testing reveals I am not following the recommended dosages for my prescriptions or the testing reveals I have used illegal or street drugs.
   - *My behavior is inconsistent with the responsibilities outlined above, which may also result in being discharged from receiving further care from this clinic following guidelines set forth by the Texas State Medical Boards.*

SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF OPIOD MEDICATIONS:
There are potential adverse effects that may occur while working and taking opioid medications. These adverse effects could potentially be dangerous and cause safety risks. These include delayed reaction time, impaired judgement, drowsiness, and physical addiction. Any of these may impair your ability to drive or operate heavy machinery. These adverse effects tend to diminish over time.

ADVERSE EFFECTS OF MIXING OPIOID MEDICATIONS:
These adverse effects may be made worse when mixing opioid medications with other medications, including alcohol.

- Feeling of Anxiety
- Confusion
- Dizziness /Drowsiness
- Impaired Judgment
- Slowed or Difficult Breathing
- Constipation
- Nausea
- Vomiting
- Slow Heart Rate
- Excessive Sweating
- Difficulty Urinating
- Physical/Psych Dependence

RISKS:
Abruptly stopping the medication may lead to withdrawal symptoms. The symptoms below may be harmful if you are being treated with other co-morbid conditions. Please do not stop medications without the supervision of your provider.

- Runny Nose
- Diarrhea
- Sweating
- Rapid Heart Rate
- Difficulty Sleeping for Several Days
- Abdominal Cramps
- Shakes and Chills
- Nervousness

I have read the above **MEDICATION/OPIOID CONTRACT.** By signing this contract, I affirm that I have read, understand and accept all terms of the contract and appropriate opportunity was allocated to me by the provider to answer any and all questions that I may have prior to prescribing opioids.

Patient's Signature: _____ Date: _____

Provider's Signature: _____ Date: _____

Northwest Anesthesiology and Pain Services, PA

Legal Assignment of Benefits and Designation of Authorized Representative

Patient Name: _____

DOB: _____

Social Security Number: _____

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider group, as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. I hereby authorize the above-named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement, or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider group, to the full extent permissible under the laws, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or other insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Patient Signature Date

Northwest Anesthesiology and Pain Services, PA

OFFICE AND FINANCIAL POLICIES

Initial:_____ **Insurance**: If a referral from your primary care physician is required for your visit, it is your responsibility to obtain it. As a courtesy, we will attempt to obtain it on your behalf, but failure to obtain the referral would require you to reschedule your appointment, unless you choose to be seen as a self-pay patient. If you confirmed your visit with our office and arrive with no referral, a rescheduling fee (also termed "No Show Fee") may be applied because your allocated time slot was confirmed with your acknowledgement of responsibility for obtaining a referral.

Initial:_____ **Forms Surcharge (at the discretion of your physician)**:
Disabled Parking Applications, and Private Disability Insurance forms (No Charge).
$50.00: Family Medical Leave Act forms, Bad Check Fees, and Credit Card Deferment forms.
$150-300 (depending on complexity) for dictated letter describing medical care and limitations.

Initial:_____ **Check In and Financial Policy**: Please bring your insurance card and photo ID. You are required to notify our office when your insurance policy changes. Please be prepared to pay any co-payments or co-insurances or past due balances, which we will notify you through our online portal or communication with the billing company. In the event that your plan determines a service to be "not covered", you will be responsible for the entire charge.

Initial:____ **No Shows, Late Cancellations, Procedural Cancellation and Late Arrivals**: We ask that you give us a courtesy call 24 hours in advance if you must cancel your office appointment. We will attempt to confirm your visit 24-48 hours prior to the visit. *No-showing for a confirmed appointment/procedure or canceling within the 24 hour period will result in a **$50 charge** to your account.* Arriving 15 mins past your arrival time may require a rescheduling of your appointment, so as not to inconvenience other patients. Over 30 mins late will automatically cancel your appointment for rescheduling. All late fees are subject to provider discretion.

Initial:_____ **Refill Requests**: Please allow 48 hours to process all prescription refill requests. Therefore, schedule a medication refill visit >48 hours to completion of prescribed controlled substances. Prescription refill requests will not be accepted after hours or on weekends. No exceptions.

Initial:_____ **Minors**: Guardian(s) accompanying patients that are minors are responsible for any financial responsibilities as well as providing current insurance information for the minor.

Initial:_____ **Medical Records**: Please note that Northwest Anesthesiology and Pain Services, PA has an active contract with HealthMark Group to fulfill all medical record requests. All urgent requests/copies of your medical records can be made available upon request at a normal **charge of $25.00** *for the first 20 pages and $0.50 per page thereafter*. A medical records release must be completed and submitted to request a copy of your records.

Initial:_____ **Office Based Procedures:** Office based procedure visits are not early medication refill visits and may require a copay. The medication refill visit will need to be scheduled on a separate visit date.

I have read, understand and agree to the above office and financial policies. I agree to be bound by its terms. I hereby attest that I have provided current and accurate demographic and insurance information. In addition, I authorize release of information necessary for insurance filing and precertification by signing this statement. I am herein authorizing payment of medical benefits to my provider when an assigned claim is filed.

Patient Name: _____ DOB: _____

Patient's Signature: _____ Date: _____

Northwest Anesthesiology and Pain Services, PA

PHYSICIAN OWNERSHIP, LAB NOTICE AND FINANCIAL DISCLOSURES

Patient Name: _____ DOB: _____

PATIENT DISCLOSURE:

To All New Patients:

During the course of your medical treatment with Northwest Anesthesiology and Pain Services, PA (hereinafter NWAP), Physicians of NWAP may refer you to a hospital, ambulatory surgery center, diagnostic facility, laboratory and/or implant a medical device in which they may have a pecuniary interest in the company that owns the aforementioned.

As a patient of NWAP you have a right to be treated by physicians and at facilities of your choosing. If you elect to be treated at facilities other than those to which you have been referred, this will in no way affect the quality of your healthcare. However, your treating physician may or may not be credentialed at the facilities of your choosing and thus require you to obtain a new treating physician.

As a patient of NWAP you have the right to request and you agree that you will request that NWAP refer you to different physician, hospital, ambulatory surgery center and/or diagnostic facility if you are unhappy with the initial referral.

You will receive a bill for all services performed by our physicians and our company's toxicology laboratory. Our bills are consistent with usual and customary charges in the geographic area where the services are provided and vary based on varying elements such as diagnosis addressed, type of testing required, complexity of decision making and associated work associated to the visit. Your insurance contract is an arrangement between you and your insurance carrier. When disputes occur between you and the insurance carrier, we will assist you in those disputes, but ultimately the dispute resolution is your responsibility. Our office complies with contractually regulated billing policies and procedures of your carrier, when applicable.

Patients are responsible for full payment of charges incurred during each appointment. Our staff collects payment based on the patient's insurance coverage and benefits. **All financial responsibility amounts quoted to patient are estimates and responsibility may change once insurance has processed and paid the patient's claim.**

If you assign the benefits from any insurance or third party to Northwest Anesthesiology and Pain Service, PA for medical services provided to you. NWAP has the right to decline or accept assignment of such benefits. If these benefits are not assigned to NWAP, you, the patient, agrees to forward to NWAP, upon receipt, any insurance or third-party payments received for services rendered to you.

_____ _____

Patient Signature Signature Date

Northwest Anesthesiology and Pain Services, PA

HOUSTON PAIN SPECIALISTS

CONSENT FOR PHOTOGRAPHY, VIDEO/AUDIO RECORDINGS AND/OR TO TELEVISE PATIENTS

(Images taken for the purposes of treatment, payment and/or health care operations)

Patient Name: _____

Last **First** **M.I.**

Date of Birth: _____

I consent to have my image taken by the staff of Houston Pain Specialists , a provider for Northwest Anesthesiology & Pain Services, PA (NWAP), as described below:

I understand that my image, including photographs, digital images, video recordings, etc., will be recorded for the purpose of assisting in my care, documenting my treatment for payment reasons, and assisting in certain health care operations NWAP conducts including quality care initiatives.

For reasons other than treatment, payment, health care operations or education purposes as described above, I understand that NWAP will require me or my personal representative to sign a written authorization form in order to use or disclose my images.

I understand that NWAP will own these images, but I will be allowed to view them or obtain copies of them.

I certify this form has been fully explained to me. I have read it or have had it read to me, and I understand its contents. I agree to have my image taken by NWAP according to the conditions listed above.

_____ _____

Signature of the Patient or Personal Representative Date