RIO GRANDE PAIN TEAM

PATIENT INFORMATION

Last name First Name Middle Initial

Date of Birth Social Security Number Gender *Male Female*

Mailing Address City State Zip Code

Home Phone Work Phone Cell Phone

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician Referring Physican

How did you hear about us?

HEALTH INSURANCE INFORMATION

Primary Insurance:_____Policy:_____

Secondary Insurance:_____Policy:_____

*****WORKERS COMP INS:_____Date of Injury:__/____/_____**

********PRIVATE PAYOR, I HAVE NO HEALTH INSURANCE*:_____

Please provide us with a copy of your insurance card, if applicable.

All professional services rendered are billed to the insurance. Necessary forms will be completed to help expedite insurance carrier payments. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES that are not covered by the insurance policy, REGARDLESS OF INSURANCE COVERAGE including any services denied by insurance carrier due to insurance benefit exclusions after services have been rendered. It is also customary to pay for fees on the day of actual services, unless other arrangements have been made in advance with our billing department and approved by management.

I request that payment of authorized Medicare/Other insurance company benefits made to me or on my behalf to DENNIS SLAVIN, MD for any services furnished me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or toehr information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim/Other Insurance company claim, I permit a copy of this authorization to be used in a place of the original. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of Social Security Act &31 U.S.C. 3801-3812 provides penalties for withholding this information) Dr. Dennis Slavin has the authority to report all outstanding delinquent accounts to a collection agency after failure of receiving payment for services rendered without sending written notice.

Signature:_____ Date:_____

PAST MEDICAL HISTORY

PATIENT'S NAME_____DOB_____

DO YOU HAVE A HISTORY OF?(Check if applicable)

__Diabetes __High Blood Pressure __Heart Disease__Lung Problems __Depression
__Seizures __Blood Disease__Kidney Problems __Arthritis __Tuberculosis
__GI Problems __Cholesterol __Cancer_____ __Stroke\Year\Affected Body Parts_____

FEMALE PATEINTS ONLY(Check if applicable)

__Regular Menstrual Periods ___Date of Last Menstrual Period_____ __Hysterectomy
__Tubal Ligation
___Under Birth Control (Pills\Patch\Shot\IUD\Implant)____Other_____

CURRENT MEDICATIONS YOU ARE TAKING

Do you take any Blood Thinners? Yes \ No __Aspirin 81mg __ Aspirin 325mg __Other, if so which one:_____

1._____ 2._____

3._____ 4._____

5._____ 6._____

7._____ 8._____

9._____ 10._____

PAST SURGICAL HISTORY

__Denies Surgeries __Pacemaker Yes \ No ___SCS Medtronic\Boston Stimulator Yes \ No

_____ _____

_____ _____

_____ _____

MEDICATION ALLERGIES:_____

FOOD ALLERGIES:_____

PERSONAL\SOCIAL HISTORY

Are both parents still living? Yes \ No _____ Cause of Death? Mother_____

Father_____

Do you drink alcohol: Yes \ No __ Social _____Drinks per day

Do you smoke? Yes \ No ____Packs per day __If quit, when?_____

Do you use any street drugs(COCAINE\MARIJUANA)? Yes \ No __ Other Illicit Drug_____

Marital Status: __Single __Married __Divorced __Widowed __With whom do you live?

_____

Are you currently working? Yes \ No __Disable, since when and reason_____ __Retired

Do you get the Flu Shot? Yes \ No When did you got shot?_____

Do you get the Pneumonia Shot? Yes \ No When did you got shot?_____

Do you attend Adult Activitiy Center? Yes \ No Where\Name of Center:_____

Who is your Primary Doctor?_____ Who is your Cardiologist?

_____

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT
AREQUIRED BY THE TEXAS MEDICAL BOARD

NAME OF PATIENT: _____ DOB:___/___/____ *** Your Pharmacy**: _____

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

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (**Dennis Slavin, MD**) and such associates, technical assistants, nurses and other health care providers as he may deem necessary or advisable, to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent to administer or prescribe the prescription(s) for dangerous and/or scheduled drugs (medications) as an element in the treatment of my chronic pain.

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

THE SPECIFIC MEDICATION (S) THAT MY PHYSICIAN PLANS TO RPESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAT WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (this is sometimes referred to as "OFF-LABEL" prescribing) MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND UNDERSTAND that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks (Urine, Saliva ,Blood) or any psychological evaluations or other test indicated and deemed necessary , and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. Presence of unauthorized substances or absence of authorized substances may result in my being discharge 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 during my course of treatment. I promise and it **is MY responsibility** to inform my physician and/or his/her appropriately authorized assistant(s) immediately if I become pregnant.

If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY. Besides the possible risks involved with the long-term use of medication(s) i.e. opioids /narcotic(s), I further understand that information on the effects of medication(s) on pregnant women and their unborn children is at present inadequate to guarantee that I and/or my unborn children may not experience significant or serious side effect(s).

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) to assure complete safety to my child. With full knowledge of this, I consent to its use and hold my physician and all staff harmless for injuries to the embryo/ fetus / baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention, 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 will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction times might still be slowed. Such activities include but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself/ or herself.

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

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. An appropriate treatment goal may even mean the eventual withdrawal from the use of all medication(s). 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 medications(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 provided medical supervision if needed when discontinuing medication use.

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

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:
That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician and/or any appropriately authorized assistant(s). 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 adhere to the rules specified in this Agreement.**

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

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the medication(s) may be discontinued.
- **I will disclose** to my physician all medication(s) that I take at any time, prescribed by any physician.
- **I will** use the medication(s) **exactly as directed by my physician** and /or his appropriately authorized assistant(s).
- **I agree not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- **I will not participate in the diversion of my medication**; **nor will I give or sell them** to anyone else.
- **All medication(s) must be obtained at one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician and/or his appropriately authorized assistant(s) to release my medical records to my pharmacist at his/her discretion and I will provide my pharmacist a copy of this agreement.
- **My pain management physician will manage the chronic pain symptoms**. All other health related issues must be managed by my primary care physician.
- **I understand** that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money**. If either are lost or stolen, they may NOT BE REPLACED.**
- **Refill(s) will not be ordered before the scheduled refill date**. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- **I will receive medication(s) only from ONE physician** and/or his appropriately authorized assistant(s) **unless it is for an emergency or** my physician approves the medication(s) that is being prescribed by another 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 and/or his appropriately authorized assistant(**s) that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician and/or his appropriately authorized assistant(s) may try alternative medication(s) or may taper me off all medication(s**). I will not hold my physician or his appropriately authorized assistant(s) and/or any member of his staff liable for problems caused by the discontinuance of medication(s).
- I **agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/ psychotherapy.
- **I recognize** that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.
- **I agree** that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- **I hereby** give my physician and/or his appropriately authorized assistant(s**) 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 and/or his appropriately authorized PA-C/ assistant(s). **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 and/or his appropriately authorized assistant(s) or my treatment may be discontinued.
- I understand many prescription medications for chronic pain produce serious side effects including drowsiness, dizziness, and confusion. Alcohol will enhance all of these side effects and should be discontinued before starting these medications.

*I certify and agree to the following:

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

2) **I have never been involved** in the sale, illegal possession, 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 I would otherwise continue to have chronic pain.

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

_____ _____ Today's Date: _____/_____/2018*

Name and Location of Pharmacy Patient Signature

_____

Physician Signature (or Appropriately Authorized Mid –Level PA-C)

WHAT IS YOUR PHARMACY OF CHOICE: _____located at: _____

ARE YOU CURRENTLY TAKING ANY BLOOD THINNERS AND OR ANY ASPIRINS MEDICATION? (Yes) (NO)
Which ONE: _____

Consent to Treatment/Financial Responsibility Consent

I desire to be treated at Dr. Dennis Slavin medical office. I understand that I may discontinue treatment at any time.
I understand that in order to receive appropriate treatment, I will undergo a clinical evaluation consisting of, but not limited to, a medical history and evaluation, and may include an x-ray, MRI, physical therapy evaluation, physical capacities evaluation, and psychological assessment. The purpose of the evaluation is to assist in identifying the cause of my problem and applying the most effective medical treatments possible.

1. I consent to being photographed for identification purposes.

2. As part of the medical procedures or tests, I understand that I may be tested for Urine Toxicology, H.I.V. infection and/or hepatitis, or any other blood-borne infectious disease at random, if a doctor orders the test for diagnostic purposes.

3. Guarantee of Payment: I agree to be responsible to the center for charges resulting from services and supplies rendered at its prevailing rates. I agree all bills are due in full upon demand. Should I fail to honor this agreement, I agree to pay any collection cost or attorney fees resulting from the collection of my accounts. I am responsible for any special medication orders made to my name if I happen to cancel the appointment without a prior cancellation notice(72HRS PRIOR NOTICE). Special orders are made only once all parties involved have confirmed and agree to all medical fees. Regardless to Insurance benefit-coverage.

Non-participating Insurance Plans/HMO:
As a service and courtesy to our patients, non-participating health insurance plans will be billed as non-assigned claim. Any outstanding balances are the responsibility of the patient.

4. Assignment of Benefits (other than Medicare and Medicaid): I hereby assign all rights and privileges and authorize payment directly to the center for any claim filed on my behalf or on the behalf of the person for whom I am duly authorized to sign for insurance benefits. I agree this assignment is primary to any assignment given after this date including any cost relative to attorney fees. I also understand that I am financially responsible to the center for co pays, deductibles, coinsurance due at the time of service, and charges not covered by this assignment or by my insurance plan or not paid on a timely basis by the insurance company.

5. Assignment of Benefits (Medicare and Medicaid): I request that payment of authorized Medicare and/or Medicaid benefits be made to the center or on my behalf for any servitor supplies furnished by the center, including physician services. I authorize any holder of medical or other information about me to release it to the Center for Medicare and Medicaid Services and its agents or to the Kentucky Medicaid Program and its agents, as appropriate, any information needed to determine these benefits or benefits for related services. I understand that I am responsible for any coinsurance, unmet deductibles, and services and items not covered by Medicare and/or Medicaid. CO-PAYS AND OR DEDUCTIBLE FEES WILL BE COLLECTED ON THE DAY OF SERVICES PRIOR TO SEE A PHYSICIAN IN THIS OFFICE..

6. The assignment of benefits is intended to grant to the center all rights that I may have in connection with benefits or other rights, under ERISA, any plan documents applicable to me, or applicable laws or regulations, including Medicare and Medicaid, associated with the services to the same extent, and to the fullest extent that I would be entitled or have the power to exercise such rights on my own behalf or on behalf of my covered dependents.

7. I give my consent for the phone numbers listed to be used to contact me for medical office purposes.

8. RETURNED CHECK FEES DUE TO NSF(INSUFFICIENT FUNDS)
Any returned check from the bank for non-payment (insufficient funds) shall result in the patients account being assessed a $50.00 fee per check returned. This office will not re-deposit NSF check, patient must pay the returned check amount including the $50.oo returned fee in CASH only.

9. Specialty Referrals:
If your insurance requires you to choose a primary care physician (PCP), you may need to have a prior authorization completed by your PCP prior to seeing a specialist (pain specialist, Sport Medicine, Physical Therapist and certain ancillary services) it is the patient responsibility to ensure a prior authorization is obtained. All charges incurred without a required prior authorization will be the responsibility of the patient.

I herby authorize all professional staff to release any information acquired in the course of the examination and treatment to: (1) referring physician; (2) insurance company; (3) worker's compensation carrier;(4) the Center's attorneys and consultants in accordance with applicable privacy laws.

*I understand that if I missed my assigned appointments (3)times consecutively, those will be ground for dismissal from care and I will be refer back to my primary doctor, and there will be no further actions.

I have read and understand this financial policy and agree to abide by the terms and expectations listed above. This financial policy is intended to promote a clear understanding of the financial policy for DR. DENNIS SLAVIN.

Date _____ **Patient Signature** _____

Dennis Slavin, M.D., P.A.

AUTHORIZATION TO REQUEST HEALTH INFORMATION

I hereby authorize the request of information from the medical record of:

Patient name:_____ Date of birth_____/_____/_____

I authorize the following individual or organization to disclose the above named individual's health information:

Name/Facility: _____

Phone:_____ Fax:_____

This information may be released to and used by the following individual or organization:

Rio Grande Pain Team-Dennis Slavin, MD, PA

910 E. 8th st. ste1 Weslaco Tx 78596 P.956-973-0565 F.956-973-0683

Please release the following records;_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that the information requested is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing the information. I understand that the revocation will not apply to the information already released in response to this authorization. I understand that the revocation does not apply to My Insurance Company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization remains active during my tenure as a patient under the services of Dr. Slavin. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may Inspect or copy the information to be used or disclosed. I understand that any disclosure of information carried with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of my health information, I can contact the Medical Records Dept.

_____ _____/_____/_____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient(If legal Representative) Witness

Request sent by:_____@Rio Grande Pain Team/Medical Records

PRESCRIPTION REQUEST CONSENT-PATIENT RESPONSIBILITIES

PATIENT'S NAME: _____ DOB:_____

_____ I am aware that it is my responsibility to be pro-active and request my medication refill at least 3 days prior to my next refill date. If a refill will be due on a weekend I will call 5 days prior to due date.

_____ I am aware that Dr. Slavin will not honor same day refill request.

_____ I am aware that at times I may be required to follow up first, or have a urine screen done before refill is given.

_____ I am aware it is my responsibility to bring any medication Dr. Slavin is prescribing on each office visit. (A pill count will be done on each visit.)

_____ I am aware that Urine Drug Screens are done due to Opioid treatment and that urine is sent out to another laboratory to get analyzed.(if you receive a invoice from said lab you must direct all questions to them.)

PATIENT SIGNATURE _____ DATE _____

NOTICE OF PRIVACY PRACTICES --- ACKNOWLEDGEMENT

Rio Grande Pain Team keeps on file a medical and billing record of all the health care services that were provided to you by us. This may include physician notes; lab and radiology reports, consult notes and other health care information that helps us provide you quality health care. It is your right to ask to obtain a copy of that record. You also may ask for the record to be changed or corrected if you see a discrepancy. Rio Grande Pain Team will not disclose this information without your authorization or where the law allows for treatment, payment, or healthcare operations. We will release this information when federal or state laws require us to do so. Should you desire copies of your medical record or other protected health information, please contact office supervisor, Mari Slavin **Medical Record fee may apply.*

I authorize Rio Grande Pain Team physicians to share or discuss the medical plan of care with immediate family next of kin or others involve in the care or payment for services rendered in this office. .

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____

Patient or legally authorized individual signature **Date** **Time**

_____ _____

Printed Name Relationship

THIS FORM WILL BE RETAINED IN YOUR MEDICAL RECORD.