Precision Spine & Pain Management

REGISTRATION FORM

Provide Insurance Cards with Picture ID to Receptionist

(Please Print)

PATIENT INFORMATION					
Patient Last Name:	**First Name:**	**Middle Name:**	**Date of Birth**	**Sex**	
				❑ M	❑ F
Marital Status: Single/ Married/ Divorced/ Widow/ Domestic Partner/ Separated			**Home Phone:** ( )		
Race/Ethnicity: (Check all that apply) ❑ Decline ❑American Indian ❑Hispanic/Latino/Spanish ❑African American ❑Cuban ❑Asian/Other ❑Puerto Rican ❑Pacific Islander/Other ❑White ❑Other: _____		**Language:** ❑English ❑Spanish ❑Other: _____	**Alternate Phone:** (_____) _____ **E-mail:**		
Street address:				**Social Security number**:	
City:	**State:**			**Zip Code:**	
Employer			**Employer Phone Number:**		

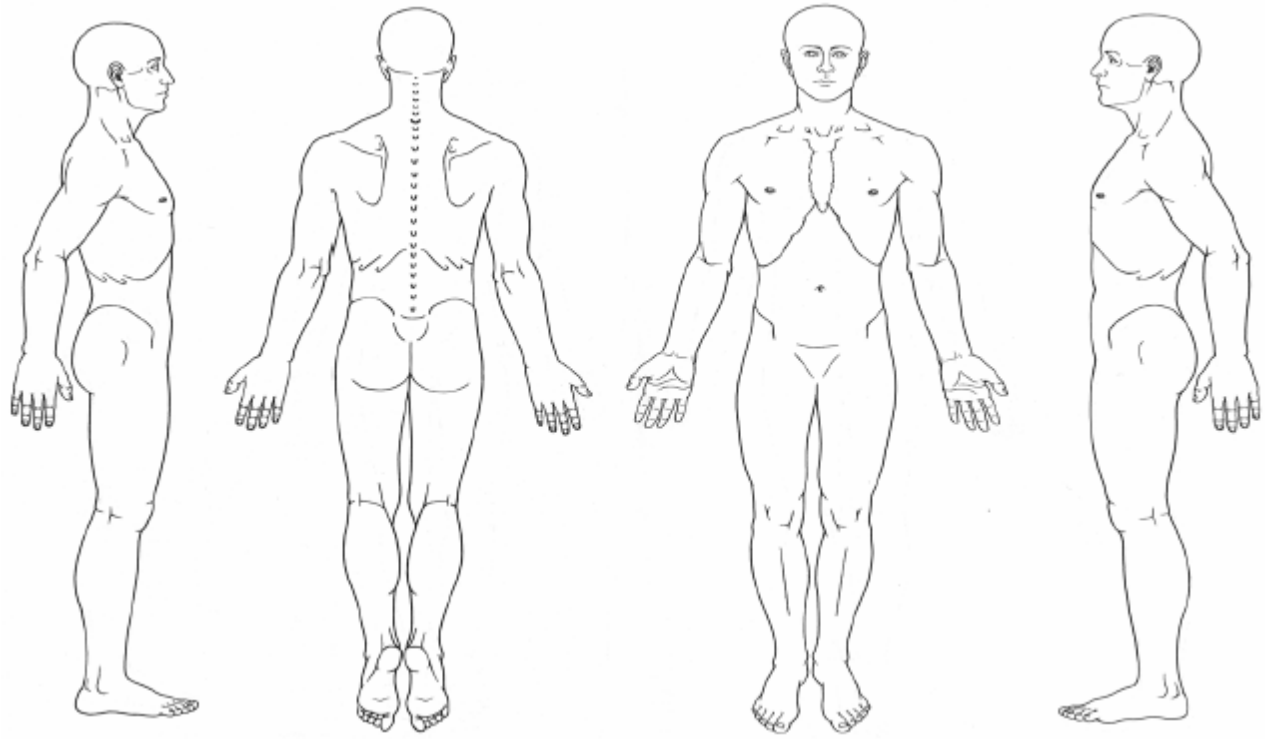
INSURANCE INFORMATION					
Please Indicate (P) for Primary Insurance and (S) for secondary insurance					
❑ Medicare	❑ Medicaid	❑ Blue Cross	❑ Aetna	❑ Cigna	❑ UHC
❑ Humana	❑ Workers Comp	❑ Tricare	❑ Other		
Primary Subscriber's name:		**Subscriber's S.S. #:**		**Birth date:**	
Secondary Subscriber's name:		**Subscriber's S.S. #:**		**Birth date:**	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Spouse	❑ Other	

IN CASE OF EMERGENCY		**Phone Number**
Name:	Relationship:	
Referring Provider		**Phone Number**
Pharmacy Name		**Phone Number**
How Would You Like Your Appointments Confirmed?		**Phone Number**
❑ Automated Calls ❑ SMS (Text Messaging) Mobile Carrier: _____		

Patient Name: _____

New Patient CONFIDENTIAL QUESTIONAIRE

Mark on the picture where you are having pain.
Mark (X) for Numbness, Mark (T) for Tingling, Mark (B) for Burning



Is your pain mostly in your ☐Neck ☐Arm ☐About the same
OR ☐ Back ☐ Leg ☐ About the same

	None									Unbearable
How bad are your symptoms today?	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9 ☐10
How bad are your symptoms at their best?	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9 ☐10
How bad are your symptoms at their worst?	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9 ☐10

Duration of pain: ☐less than 1 week ☐1-4 weeks ☐1-3 months ☐3-6 months ☐6-12 months ☐more than 1 year

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

How has the pain intensity changed since it began? ☐Increased ☐Decreased ☐No Change

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

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

Do you have ALLERGIES to any medications? ☐**Yes** ☐**No**
If YES please list: _____

Patient Name: _____

Precision Spine & Pain Management

How do the following factors affect your pain? (Check one per line)

	Better	Worse	No Effect		Better	Worse	No Effect		Better	Worse	No Effect
Heat	☐	☐	☐	Climate	☐	☐	☐	Sleeping on back	☐	☐	☐
Cold	☐	☐	☐	Fatigue	☐	☐	☐	Sleeping on stomach	☐	☐	☐
Lying down	☐	☐	☐	Coughing	☐	☐	☐	Straining	☐	☐	☐
Sitting	☐	☐	☐	Massage	☐	☐	☐	Sex	☐	☐	☐
Walking	☐	☐	☐	Alcohol	☐	☐	☐				
Sneezing	☐	☐	☐	Lifting	☐	☐	☐				

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

Do you have any? ☐Urinary Incontinence ☐Stool Incontinence ☐Sexual function disturbance

Check the treatments you have had for pain; please provide treatment dates

☐Acupuncture _____ ☐Physical Therapy _____ ☐Biofeedback _____
☐Exercise _____ ☐Psychotherapy _____ ☐TENS Unit _____
☐Facet Blocks _____ ☐Epidurals _____ ☐Nerve Blocks_____
☐Trigger Point _____ ☐Massage _____ ☐Hypnosis _____
☐Chiropractor_____ ☐Brace _____
☐Other _____

Do you smoke? ☐Yes ☐No How many packs per day? _____ How many years? _____
Do you drink alcohol? ☐Yes ☐No How much per day? _____ How many years? _____
Do you use illicit drugs? ☐Yes ☐No How much per day? _____ How many years? _____

PAST SURGICAL HISTORY (mark surgeries you have had, please provide approximate date)

☐Appendectomy _____ ☐Tonsillectomy/Adenoids _____ ☐Gallbladder Surgery _____
☐Coronary Bypass _____ ☐Hernia Repair _____ ☐Hemorrhoid _____
☐Tubal Ligation _____ ☐Mastectomy _____ ☐Hysterectomy/Partial _____
☐Breast Biopsy _____ ☐Prostate _____ ☐Vasectomy _____
☐Knee Replacement _____ ☐Hip Replacement _____ ☐Knee Surgery _____
☐Shoulder Surgery _____ ☐Cataracts _____ ☐Colon _____
☐Back Surgery _____ ☐Neck Surgery _____ ☐Other _____

Women: Are you pregnant? ☐Yes ☐No ☐Not Sure **Patients Initials** _____

PAST MEDICAL HISTORY

REVIEW OF SYSTEMS

Constitutional: ☐Obesity ☐Weight loss ☐Weight gain
☐Chills ☐Fever ☐Fatigue

Musculoskeletal: ☐Arthritis ☐Fibromyalgia ☐Muscle Spasms
☐ Numbness ☐ Weakness

Neurological: ☐Headache ☐Seizures ☐Migraines ☐Stroke
☐Confusion ☐Dizziness ☐Light Sensitivity ☐Loss of Consciousness

Psychiatric: ☐Depression ☐Substance Abuse☐Anxiety ☐Bipolar ☐Schizophrenia
☐Anxiety ☐Suicidal thoughts ☐Difficulty Sleeping

Cardiovascular: ☐Angina ☐Heart Attack ☐Heart Stent ☐Pacemaker ☐High Blood Pressure (Hypertension)
☐Chest Pain ☐Palpitations

Respiratory: ☐Asthma ☐Emphysema ☐Chronic Bronchitis ☐Lung Cancer
☐Cough ☐Shortness of Breath ☐Blood Cough

Patient Name: _____

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Gastrointestinal: ☐Reflux ☐Hepatitis ☐Ulcers ☐Incontinence ☐Diarrhea ☐Constipation ☐Abdominal Pain
☐Irritable Bowel Syndrome ☐Cirrhosis ☐Heartburn ☐Bloating ☐Nausea ☐Vomiting
☐Diverticulitis ☐Colon Cancer ☐Bloody Stools ☐Painful Bowel Movement

Genitourinary: ☐Impotence ☐Kidney Stones ☐Incontinence ☐Decreased Libido ☐Urinary Frequency
☐Urinary Tract Infection ☐Cancer ☐Prostate Problems ☐Urinary Hesitancy

Integumentary: ☐Herpes Zoster/Shingles ☐Skin Cancer ☐Rash ☐Swelling

Endocrine, Hematologic, Allergy/Immunologic, HEENT:
☐Diabetes ☐Hypothyroidism ☐Hyperthyroidism ☐HIV ☐Easy Bruising ☐Ringing in Ears
☐Hyperlipidemia (Elevated Cholesterol) ☐Leukemia ☐Visual Changes
☐Lymphoma ☐Multiple Myeloma ☐Cancer: _____

Rheumatologic: ☐Lupus ☐Sjogren's ☐Scleroderma ☐Polymyalgia Rheumatica ☐Painful Joints ☐Blurry Vision
☐Rheumatoid Arthritis ☐Multiple Sclerosis ☐Other: _____

Family History

	Diabetes	Heart	Anxiety	Kidney	Cancer	Depression	Back	Other Conditions
Mother	☐	☐	☐	☐	☐	☐	☐	
Father	☐	☐	☐	☐	☐	☐	☐	
Brother(s)	☐	☐	☐	☐	☐	☐	☐	
Sister(s)	☐	☐	☐	☐	☐	☐	☐	

Current Medication List

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

Past Pain Medication Tried

Medication	Medication	Medication	Medication

I acknowledge that I have completed this questionnaire accurately and to the best of my knowledge.

_____ _____
Patient/Legal Representative Signature **Date**

Patient Name: _____

SOAPP® Version 1.0-14Q

Name: _____ Date: _____

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

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

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

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

The SOAPP® was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

Precision Spine and Pain Management, P.L.L.C.

Financial Policy

1. *Proof of Insurance:*
   Payment is due at the time of service, which includes applicable co-pays, deductibles and co-insurance. Please bring your insurance card(s) with you to every appointment. It is your responsibility to inform the front desk when a change of insurance has occurred, or when the cause for treatment should be billed to a liability insurance company or worker's compensation instead of your regular primary insurance. Verification of benefits is required. If benefits are unable to be verified, you are responsible. All charges are your responsibility whether your insurance company pays or does not pay. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, etc.
2. *Payment is due at time of service:*
   We accept cash, personal checks, debit and credit cards. **All deductibles, copays, and non-covered services are due at time of service unless payment arrangements have been made in advance.** If you have Medicare, but Medicare may deem the treatment as "medically unnecessary" according to HCFA payment guidelines, you will be required to sign a waiver (advanced beneficiary notice) prior to treatment and the service is due at the check-out counter. All Medicare patients will be required to pay the 20% copay based upon the current Medicare Fee Schedule at the check-out counter unless proof of a secondary policy is evident. Pre-determined copays are due when you check-in for your appointment. If your copay is based on a percent (example 20% is patient responsibility) and you do not have a secondary policy, please be prepared to pay. Insurance claims are filed as a courtesy; you are ultimately responsible for the rendered services. **If the insurance balance is not paid within 90 days, the balance may be released to you.**
3. *Our responsibility to Report Non Compliance:*
   It is our obligation under many of the managed care contracts to report patients who repeatedly refuse to pay copays and deductibles at time of service or who are repeatedly "No-Show" for appointments. Please know that if you are reported, you could possibly lose your health care benefits. Contact human resources with your employer for further clarification of your benefits and obligations.
4. *Financial Assistance:*
   Our office treats patients regardless of financial status. If you have no insurance, have maximized your benefits, have a high deductible or you are currently medically indigent or financially indigent but not eligible for Public Assistance or Medicaid, please ask to speak with the Office Manager.
5. *Billing, Payments, and Over Payments:*
   If an overpayment is made by you on the account, a refund will only be issued in a timely fashion if there are no other outstanding debts on the other accounts containing the same guarantor or financial responsible party. Patient balances unforeseen at time of service will be billed to the address you have provided for billing purposes. It is your responsibility to inform us of any changes in address, phone, or employment. All balances are due in full within 14 days of the billing date. Miscellaneous applicable fees include, but are not limited to: **$25.00-$50.00 for Appointment "No-Shows", return checks and designated document request fee(s). Please refer to our Office Protocol Agreement or ask administration for further details.**
6. *Past Due and Delinquent Accounts:*
   Failure to meet your financial obligations may result in reporting you to our contracted collection agency who in turn may report you to the credit bureau, filing for a judgment in small claims court or other collection action against you and you may be terminated as a patient from this facility. All attorney fees, court costs and other expense related to collecting your account will be added to your outstanding balance.
7. *Professional Courtesy Policy:*
   There will be a zero tolerance to "professional courtesy" extended to any office staff, members of the physician's family, friends, colleagues, clients, patients or referrals. The purpose of this policy is to be compliant with the Civil False Claims Act and the Anti-Kickback Statutes when making write-off's, adjustments, discounts and no charges.

Our Physician(s) require you to direct all financial concerns to the Administrative Staff.

I understand and agree that I am absolutely responsible for the balance on my account for professional services rendered.

Signature of Responsible Party _____ Date: _____

Printed Name of Responsible Party _____Date: _____

HIPAA AUTHORIZATION

STATEMENT OF INTENT

It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits disclosure of my protected medical information. This authorization is being signed because it is crucial that my medical providers readily give my protected medical information to the persons designated in this authorization in order to allow me the advantage of being able to discuss and obtain advice from my family and/or friends.

Therefore, pursuant to 45 CFR 164.501(a)(1)(iv) a covered entity (being a health care provider as defined by HIPAA) is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR Sec. 164.508.

AUTHORIZATION

I, _____, an individual, hereby authorize all covered entities as defined in HIPAA, including but not limited to a doctor, (including but not limited to a physician, podiatrist, chiropractor, or osteopath,) psychiatrist, psychologist, dentist, therapist, nurse, hospitals, clinics, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other health care provider or affiliate, to disclose the following information:

> All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to ANY protected medical information to the persons named in this authorization.

to the following authorized persons:

Name: _____

Address: _____
_____

Telephone: _____

PHYSICIAN DISCLOSURE

As required by Section 102.006 of the Texas Occupations Code

Texas law requires a physician to disclose to a patient those arrangements permitted under applicable Texas law whereby such physician accepts remuneration to secure or solicit a patient or patronage for a person licensed, certified or registered by a Texas health care regulatory agency. The purpose of this Disclosure is to notify you, the patient, that your attending physician(s) may receive remuneration for referring you to certain diagnostic testing laboratories, pharmacies and/or other ancillary healthcare providers, for certain toxicology and pharmacogenomic testing services, compounding pharmacy products, diagnostic imaging services and other ancillary healthcare services.

Accordingly, I hereby acknowledge that my attending physician(s) have disclosed to me, at the time of initial contact and at the time of referral (i) his or her affiliation, if any, with the diagnostic testing laboratory, pharmacy or other ancillary healthcare provider for whom, I, the patient am being referred, and (ii) that he/she will receive, directly or indirectly, remuneration for the referral to such diagnostic testing laboratory, pharmacy or other ancillary healthcare provider. I understand that I, the patient, have the right to choose the providers of my health care services and/or products and, as such, I have the option of receiving ancillary healthcare services from any ancillary healthcare provider and/or facility that I choose.

Pt. Name: _____

Pt. Signature: _____

Patient Name: _____

DATE: _____ / _____ / 2014

OFFICE PROTOCOL AGREEMENT

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

I understand that refills are given at time of office visit. Refills are not done over the phone or over the weekend.

_____
(Initials)

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

_____
(Initials)

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

_____
(Initials)

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

_____
(Initials)

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

_____
(Initials)

I agree to cancel my appointments **48 hours** in advance to benefit other patients that are in need of earlier appointments. I understand that not showing up for an appointment without calling in advance may result in a charge fee of **$25.00** for an office visit and **$50.00** for a procedure, and can also be a factor in the continuation or discontinuation of my care with Precision Spine & Pain Management.

_____
(Initials)

I understand that I am to arrive 45 minutes before my appointment time to check in for a New Patient Visit and 15 minutes before my follow up visit.

_____
(Initials)

LONG-TERM CONTROLLED SUBSTANCE THERAPY AGREEMENT

I understand that my pain is **MY** responsibility. Making appointments for medication refills is **MY** responsibility. ***Precision Spine & Pain Management, PLLC*** will provide medical support in my quest to minimize my pain. I understand and I will make new efforts to improve SLEEP HABITS, NUTRITION, BODY WEIGHT, CONDITIONING, AND PSYCHOLOGICAL STATE. Narcotics are not the answer to chronic pain, but can be used effectively to improve my pain.

_____
Signature/Legal Representative

I have read the ***CONSENT FOR CHRONIC OPIOID THERAPY*** or have it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines.

_____
Signature/Legal Representative

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed Precision Spine & Pain Management 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/ Legal Representative

YOU AFFIRM THAT YOU HAVE THE FULL RIGHT AND POWER TO SIGN AND BE BOUND BY THESE AGREEMENTS, AND THAT YOU HAVE READ, UNDERSTAND, AND ACCEPT ALL OF ITS TERMS OF THIS CONTRACT.

_____
Signature/Legal Representative

_____
Description of Legal Representative

_____
Witness

INFORMATION ON NEW CONSULTATION APPOINTMENTS

We are pleased that you have been referred to our office. As part of the initial consultation, we will need you to fill out paperwork that pertain to your medical history; insurance coverage and contact information. We request that you arrive **45 minutes** before your appointment time in order check in and to allow you enough time to fill out the paperwork. We request that you bring all your medications, including over the counter medications, picture ID card and insurance cards. If your address on the picture ID is not correct, we will request another type of identification in order to confirm an accurate address.

Our purpose in your initial consultation is to provide you with the upmost and complete evaluation. In order to address your pain concerns, we need to do a clinical review of your radiological films and/or reports, labs, etc., performed within the past 3 months. Without the radiological and/or laboratory information requested, we will not be able to perform an accurate comprehensive evaluation and would be unable to provide you with review options for your care. Therefore, in order to avoid being scheduled for a second appointment please obtain your records and/or information whether it is by hand carrying or having your referring physician's office send them to our office. *Please be aware that it is **not** our office protocol to prescribe any medication during the evaluation process. If medication is a part of your treatment plan, we will see how to address the situation along with the office protocol on how the medication policy is handled in office.*

Once the evaluation has been completely performed, treatment options will be offered; if you agree and accept to be a patient in our office, beyond this point is when the patient/ provider relationship will commence. Please be assured that the evaluation is kept in the strictest of confidence. We also understand if you decide to **not** pursue a relationship with our office as a patient. We also reserve the right to proceed to have you as a patient or not, once we determine that we can or cannot be of assistance.

LONG-TERM CONTROLLED SUBSTANCE THERAPY AGREEMENT

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

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

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

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

1. All controlled substances must come from the physician who is assigned to your care or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.) You are not to receive prescriptions for narcotic or sedative drugs from any other physician.
2. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.
3. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed.
4. Unannounced urine or serum toxicology screens will be requested, and your cooperation is required. Presence of unauthorized substances may prompt termination of your opioid treatment and referral for assessment for addictive disorder.
5. Long-acting narcotics will be administered for chronic pain problems. Our goal is the discontinuation of short acting narcotics and narcotic mixtures (i.e. Percocet, Lortab, Vicodin, etc.).
6. "Rescue Doses" of short acting narcotics will not be routinely prescribed.
7. Refill will occur on a monthly basis and **ONLY** after a visit and physical examination. **NO REFILLS WILL BE MADE OVER THE TELEPHONE, GIVEN AFTER HOURS, ON WEEKENDS, AND/OR HOLIDAYS**. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.
8. If refill requests are made after hours, you will instructed by the answering service to go to an emergency room of your choice.

9. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
10. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date. Early refills will not be given.
11. Any evidence of prescriptions, forged prescriptions, substance abuse, or aberrant behavior (including verbal abuse to my office staff) will result in termination of patient-physician relationship.
12. Medications will not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc., so protect your medications. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.
13. Prescriptions are to be used ONLY as written. Use of increased amount of medication, without consultation with a physician, will not be allowed.
14. You may not share, sell, or otherwise permit others to have access to these medications.
15. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
16. Original containers of medications should be brought in to each office visit.
17. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
18. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.
19. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
20. The risks and potential benefits of these therapies are explained elsewhere [and you acknowledge that you have received such explanation].
21. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.
22. Termination terms will include a written letter to you and fulfillment of your medical needs, including narcotic prescription, for one month after the date of termination. You will be presented with the option, in lieu of termination, to receive an evaluation for drug dependency and, if appropriate, be referred for detoxification.

CONSENT FOR CHRONIC OPIOID THERAPY

A consent form produced by the American Academy of Pain Medicine.

Precision Spine & Pain Management PLLC, physician may be prescribing opioid medicine, sometimes called narcotic analgesics to me for a diagnosis that is causing me to experience pain. This decision was made because my condition is serious or other treatments have not helped my pain. I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed included:

1. Making no change to current medical regimen.
2. Discontinue current regimen completely.
3. Seeking psychological and/or psychiatric evaluation and treatment in addition to other options.
4. Initiation of physical and/or occupational therapy.
5. Seeking surgical consultation.
6. Proceeding with interventional therapy.
7. Using only non-opioid agents.

I will tell my physician about all other medications and/or treatments that I am receiving.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly.

I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: using heavy equipment, machinery or a motor vehicle, working in unprotected heights and/or being responsible for another individual who is unable to care for themselves.

I am aware that certain other medications such as nalbuphine (Nubain ™), pentazocine (Talwin™), buprenorphine (Buprenex™), and butorphanol (Stadol™),

may reverse the action of the medicine I am using for pain control. Taking any of these other medications while I am taking my pain medicine can cause symptoms like a bad flu, called or referred to as withdrawal syndrome. I agree not to take any of these medications and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medications listed above.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life.

I am aware that the chance of becoming addicted to my pain medicine is very low.

I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my physician the complete, honest personal and family drug history to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time. Physical dependence is not the same as addiction; physical dependence means that if my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief.

I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my physician to choose another form of treatment.

(**Males only**) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire, physical, and sexual performance. I understand that my physician may check my blood to see if my testosterone level is normal.

(**Females Only**) If I plan to become pregnant or believe that I have become pregnant while taking this pain medication, I will immediately call my obstetric physician and **Precision Spine & Pain Management** to inform them.

I am aware that, should I carry a baby to delivery while taking these medications; the baby will be physically dependent upon opioids.

I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that the baby will have a birth defect while I am taking an opioid.

NOTICE OF PRIVACY PRACTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice describes our privacy practices. Please review it carefully.

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

TREATMENT, PAYMENT, HEALTH CARE OPERATIONS

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

PAYMENT

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

HEALTH CARE OPERATIONS

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

DISCLOSURES THAT CAN BE MADE WITHOUT YOUR AUTHORIZATION

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If

you choose to sign an authorization to disclose information, you may later revoke that authorization in writing to stop future uses and disclosures. However revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

PUBLIC HEALTH, ABUSE OR NEGLECT, AND HEALTH OVERSIGHT

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state or local government for the collection of information about disease, vital statistics (births & deaths), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products that may be recalled.

We may also disclose medical information to a public agency authorized to receive reports on child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure application and inspections which are all government activities undertaken to monitor the healthcare delivery system and compliance with other laws, such as civil rights laws.

LEGAL PROCEEDINGS AND LAW ENFORCEMENT

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

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

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

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

WORKERS' COMPENSATION

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

INMATES

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

MILITARY, NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES, PROTECTION OF THE PRESIDENT

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

ORGAN DONATION, CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS

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

REQUIRED BY LAW

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

YOUR RIGHTS UNDER FEDERAL PRIVACY REGULATIONS

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

REQUESTED RESTRICTIONS

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

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

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

RECEIVING CONFIDENTIAL COMMUNICATIONS BY ALTERNATIVE MEANS

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

INSPECTION AND COPIES OF PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

AMENDMENT OF MEDICAL INFORMATION

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

☐ wasn't created by this practice or the physicians here in this practice.

☐ is not part of the Designated Record Set?

☐ is not available for inspection because of an appropriate denial.

☐ if the information is accurate and complete.

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

ACCOUNTING OF CERTAIN DISCLOSURES

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

APPOINTMENT REMINDERS, TREATMENT ALTERNATIVES, AND OTHER HEALTH-RELATED BENEFITS

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

COMPLAINTS

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

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

OUR PROMISE TO YOU

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

QUESTIONS AND CONTACT PERSON FOR REQUESTS

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

Precision Spine & Pain Management PLLC
Privacy Officer
1642 Lockhill Selma Road
San Antonio, Texas 78213
Phone: 210-233-9331
Fax: 210-233-9454

This notice is effective on the following date: April 14, 2003. We may change our policies and this notice at any time and have those revised policies apply all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen

ASSIGNMENT OF BENEFITS/RIGHTS FOR DIRECT PAYMENT TO DOCTOR

(PRIVATE, GROUP ACCIDENT AND HEALTH INSURANCE)

I hereby instruct and direct (_____)
Insurance Company to pay by check made out and mailed directly to: **Precision Spine & Pain Management** for professional and/or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered

MEDICARE ASSIGNMENT OF BENEFITS/RIGHTS FOR DIRECT PAYMENT TO DOCTOR

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

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

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

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

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

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

APPOINTMENT POLICY

In an effort to provide efficient treatment to all of our patients, it is the policy of this company that if you are unable to make your scheduled appointment, **you must call to cancel the appointment no later than 48 hours before the scheduled time.** If you fail to cancel your appointment and/or fail to show up to the appointment, you will be charged with a "NO SHOW" fee of **$25.00** for office visits and **$50.00** for procedures, per occurrence. For most instances plans and Worker's Compensation carriers, "NO SHOW" charges are non-covered service and you will be solely responsible for payment of this charge. Repeated "NO SHOWS" and cancellations of your scheduled appointments may result in you being DISCHARGED from care at the Precision Spine & Pain Management, PLLC. If you have any questions or concerns about this policy, our staff is available to answer your questions.

OWNERSHIP INTEREST NOTICE

☐ Certain providers who perform patient care services at this facility have ownership interest in *Hill Country Toxicology, Ltd.; SA MRI; RRR Hyperbarics & Physical Therapy*

☐ You have the right to choose the provider of your health care services. Therefore, you have the option to use a facility other than those listed above.

☐ You will not be treated differently by your provider if you choose to obtain services at a facility other than those previously listed.

Prescription Refill Protocol

In order to better serve our patients, Precision Spine and Pain Management will be adopting this policy effective immediately. The increasing volume and short notice has become too great and has affected our ability to properly triage urgent versus non urgent telephone calls.

- Once you have notified the office that you are in need of a prescription refill please allow 24 to 48 hours for your prescription to be called into the pharmacy

- Refills on **CONTROL SUBSTANCE** will **ONLY** be made during business hours and on **SCHEDULED** appointments. It is **YOUR** responsibility and is required of you to keep track of your remaining prescription and dose, so as to ensure you have enough time to schedule an appointment*. Call 7 days prior to your prescription running low and schedule an appointment. Precision Spine and Pain Management will **NOT** refill prescriptions after hours, on weekends or on holidays. If the prescription is lost, misplaced, stolen or you use the prescription more rapidly than what it is directed it will **NOT** be replaced.*

Should you have any questions and or concerns feel free to call the office at 210-233-9331 and we would be happy to assist you.

Thank you,
Precision Spine and Pain Management