ADVANCED PAIN CARE™
Pain Management

Patient Name: **Date of Birth:**

Opioid Stewardship New Patient Intake

Please take a few minutes to fill out this medical intake to facilitate your appointment today.

Past Psychiatric History

Outpatient Treatment? ☐ Yes | ☐ No
If yes please describe:

When	By Whom?	Nature of Treatment

Psychiatric Hospitalization? ☐ Yes | ☐ No
If yes please describe:

When	Where?	Reason

Past Psychiatric Medications? ☐ Yes | ☐ No
If yes please describe:

Name of Medication	Dose	How often do you take it?	What is it for?	Who prescribes it?

Are you currently seeing a Mental Health Provider? ☐ Yes | ☐ No
Provider Name: _____
Diagnosis:_____

What brings you to counseling at this time? Is there something specific, such as a particular event?
Be as detailed as you can. : _____

_____

_____

Are you having any thoughts of hurting yourself? ☐ Yes | ☐ No

Symptoms Checklist:

	Y	N		Y	N
Depressed Mood			Change In Appetite		
Racing Thoughts			Excessive Energy		
Excessive Worry			Excessive Guilt		
Unable to Enjoy Activities			Increased Irritability		
Impulsivity			Fatigue		
Anxiety Attacks			Crying Spells		
Sleep Patter Disturbance			Decreased Libido		
Increase Risky Behavior					
Avoidance					
Loss of Interest					
Increased Libido					
Hallucinations					
Concentration / Forgetfulness					
Decrease Need for Sleep					
Suspiciousness					

Have you been treated for depression, anxiety, bipolar Illness, or ADD? ☐ Yes | ☐ No

Do you have any history of substance abuse such as alcohol marijuana, cocaine, methamphetamine, heroin, pain medications, or other? ☐ Yes | ☐ No

Do you use Illicit Substances? ☐ Yes | ☐ No

Do you have gambling problems? ☐ Yes | ☐ No

Have you ever been to a substance abuse treatment program, either inpatient or outpatient? ☐ Yes | ☐ No

Have you ever been arrested for DWI, public Intoxication, or possession of controlled substance? ☐ Yes | ☐ No

Do you have a family history of substance abuse or psychiatric illness? ☐ Yes | ☐ No

Have you ever had an adverse reaction to opioid pain medication including overdose, tolerance, or withdrawal? ☐ Yes | ☐ No

Preferred Pharmacy: Advanced Rx Other: _____

Advanced Rx pick up or mail next day available (Shipping and Handling included).

Patient Signature:_____Employee's Initials:_____Provider's Initials:_____

ADVANCED PAIN CARE™
Pain Management

Patient's Name: **Date of Birth**:

New Patient Intake- Pain Management

About Your Pain:

Chief Complaint (Reason for visit) :_____

Where is the exact location of your pain today? _____

When did you first have this pain?_____

Describe your pain (aching, burning, cramping, etc.):_____

Is the pain Constant? Yes | No How long does the pain last?_____

Rate your pai No Pain- 1 2 3 4 5 6 7 8 9 10- Worst Pain

Rate your pain with meds (if applicable): 1 2 3 4 5 6 7 8 9 10

What makes you pain worse?_____Better?_____

What medication are you taking for pain (if applicable)?_____

What medications have you tried in the past?_____

Are your pain medications working as well as they could? Yes | No If no, genetic testing could be the answer.

Preferred Pharmacy: Advanced Rx Other: _____

Advanced Rx pick up or mail next day available (Shipping and Handling included).

What previous treatments for this pain?_____

Have you tried Physical Therapy? Yes | No When?_____

Have you been treated by a previous Pain Specialist? Yes | No When?_____ By who?_____

Patient's Name: **Date of Birth**:

Medication History

Name of Medication	Dose	How often do you take it?	What is it for?	Who prescribes it?

Do you have any medication/drug allergies? Please list:_____

_____

Past Medical History

Type of Surgery	Details	Date and Hospital

Hospitalizations other than surgery (include date and facility name):_____

_____

Condition/ Diagnosis	Details	Treating Physician

Any details:_____

_____

Type of Imaging	Body Part	Facility Name

Patient's Name: **Date of Birth**:

Social History

Any tobacco use? Yes | No Packs per day _____ for _____ years.

Any alcohol use? Yes | No Drinks per day _____ for _____ years.

Any recreational drug use? Yes | No Drugs used_____

Any special diet? Lactose free Caffeine Free Diabetic Vegetarian Vegan Other

_____

Marital status? Single Married Divorced Widow/ Widower Are you currently working? Yes | No

If no: Who took you off work?_____ If yes: What is your occupation?_____

When did you stop working (if applicable)? _____

Family History

Has your mother ever had: Diabetes | Hypertension | Cancer| Other_____

Has your father ever had: Diabetes | Hypertension | Cancer| Other_____

Have any of your siblings ever had: Diabetes | Hypertension | Cancer| Other_____

Have any of your children ever had: Diabetes | Hypertension | Cancer| Other_____

Has your mother's parents ever had: Diabetes | Hypertension | Cancer| Other_____

Has your mother's siblings ever had: Diabetes | Hypertension | Cancer| Other_____

Has your father's parents ever had: Diabetes | Hypertension | Cancer| Other_____

Has your father's siblings ever had: Diabetes | Hypertension | Cancer| Other_____

Any other family history and relation to you:_____

Review of Systems

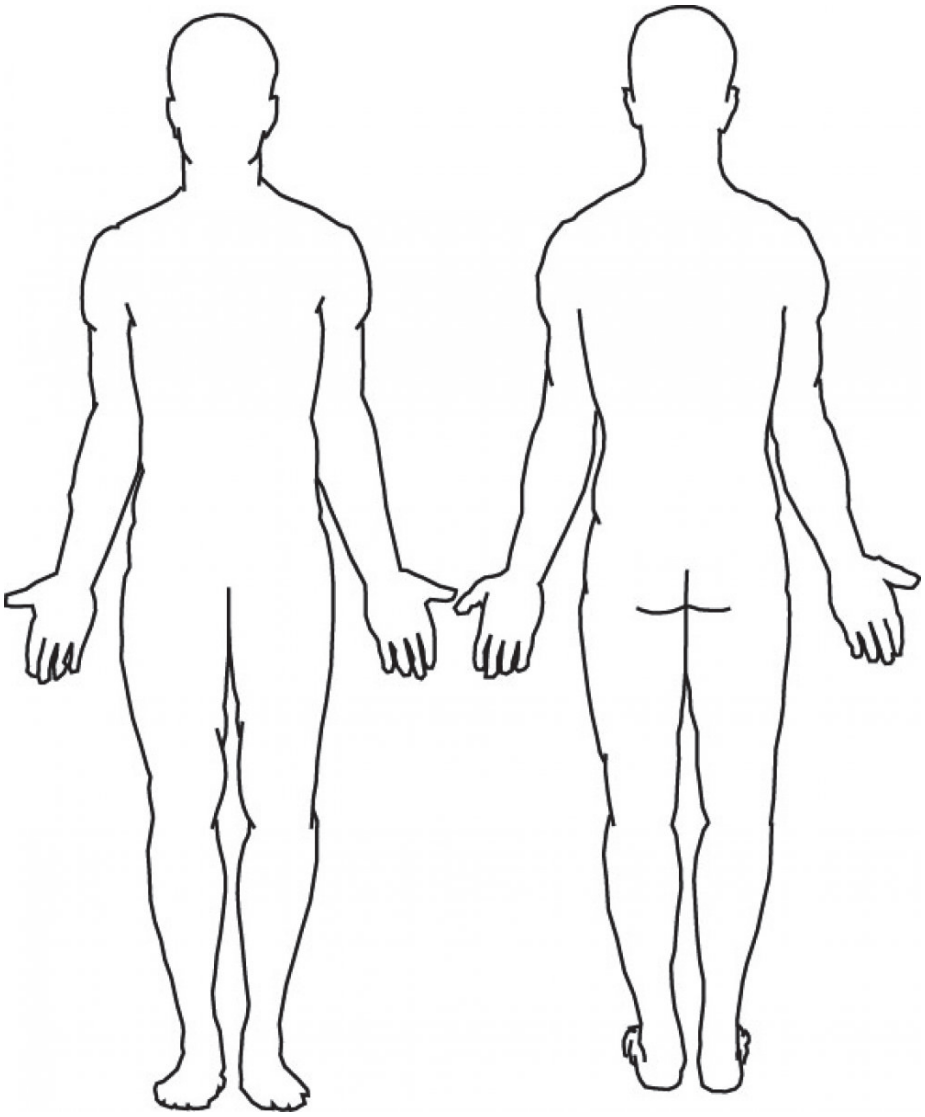
	Y	N
GENERAL		
Decreased Appetite		
Unexpected Weight Loss		
Unexpected Weight Gain		
Fatigue		
Fever or Chills		
Other		
NEURO		
Headache		
Strokes / CVA		
Seizures		
Other		
RENAL/URINARY		
Renal Failure/Insufficiency		
Electrolyte Disturbances		
Kidney Stones		
Difficulty Urinating		
UTI		
Prostate Cancer		
Other		
RESPIRATORY		
Sleep Apnea		
Complications with Sedation		
Chronic Bronchitis		
Difficult Breathing		
Persistent Coughing		
Asthma		
Other		
SKIN		
Rash		
Itching		
Unusual Hair		

	Y	N
GASTROINTESTINAL		
Nausea / Vomiting		
Abdominal Pain		
Irregular Bowel Habits		
Loss of Control of Bowels		
Jaundice		
Gallstones		
Hepatitis		
Cirrhosis		
Fluid In Abdomen		
Pancreatitis		
Other		
CARDIOVASCULAR		
Chest Pain		
Coronary Artery Disease		
High Blood Pressure		
Swelling In Feet		
Abnormal Headaches		
Other		
BLOOD/LYMPH		
Anemia		
HIV		
Bruise Easily		
Past Blood Transfusion		
Swollen / Tender Lymph Nodes		
Cancer		
Other		
ENDOCRINE		
Diabetes		
Thyroid Problems		
Osteoporosis		
Other		

	Y	N
HEENT		
Blind Field of Vision		
Cataracts		
Hearing Loss / Ringing		
Sore Throat / Hoarseness		
Other		
MUSCOLOSKELETAL		
Joint Pain / Arthritis		
Back Pain		
Neck Pain		
Muscle Aching		
Other		
PSYCH		
Drug Abuse / Addiction		
Depression		
Anxiety		
Suicide Attempt		
Other		

Patient's Name: **Date of Birth**:

Please shade your area(s) of pain



Patient Signature:_____**Employee's Initials**:_____**Provider's Initials**:_____

ADVANCED PAIN CARE™
Pain Management

INFORMED CONSENT

Patient's Name: Date of Birth:

AS REQUIRED BY THE TEXAS MEDICAL BOARD REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER *170 3 Rd Edition: Developed by the Texas Pain Society, April2008 (www.texaspain.org)*

PLEASE INITIAL EACH PARAGRAPH SIGNIFYING CONSENT AND UNDERSTANDING

_____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/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

_____CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain. It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).
THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

_____I HAVE BEEN INFORMED AND UNDERSTAND that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from your care.

_____I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

Patient's Name: Date of Birth:

FOR FEMALE PATIENTS ONLY:

_____To the best of my knowledge **I AM NOT PREGNANT**. If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment.

_____I accept that it is **MY RESPONSIBILITY** to inform my physician immediately if I become pregnant.

_____If I am pregnant or am uncertain, **I WILL NOTIFY MY PHYSICIAN IMMEDIATELY**. All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/ fetus / baby.

_____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.

_____**I REALIZE** that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me.

_____**I UNDERSTAND** that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use.

_____**I FURTHER UNDERSTAND** that I will be provided medical supervision if needed when discontinuing medication use

_____**I UNDERSTAND** that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit.

_____ **I HAVE BEEN GIVEN THE OPPORTUNITY** to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

Patient's Name: Date of Birth:

_____DURING THE COURSE OF YOUR PHYSICIAN/PATIENT RELATIONSHIP with Advanced Pain Care, you may be prescribed medication that can be filled at Advanced Rx Pharmacy. The address of the Pharmacy is 2000 South Mays Street Suite 200, Round Rock, TX 78664. You are hereby advised that Advanced Pain Care has an investment interest in the Pharmacy. This information is being provided to help you make an informed decision about your health care. You have the right to choose your pharmacy. You have the option of obtaining the prescription ordered by your physician at Advanced Rx Pharmacy or at any other pharmacy you select. You will not be treated differently by your physician, Advanced Pain Care or Advanced Rx Pharmacy if you choose to use a different facility.

_____ **DURING THE COURSE OF YOUR PHYSICIAN/PATIENT RELATIONSHIP** with Advanced Pain Care (Austin Area), you may undergo procedures that will be performed at Round Rock Surgery Center. The address of the Surgery Center is 2000 South Mays Street Suite 400, Round Rock, TX 78664. You are hereby advised that Ryan Michaud, MD has an investment interest in the Surgery Center. This information is being provided to help you make an informed decision about your health care. You will not be treated differently by your physician, Advanced Pain Care or Round Rock Surgery Center if you choose to use a different facility.

_____ **DURING THE COURSE OF YOUR PHYSICIAN/PATIENT RELATIONSHIP** with Advanced Pain Care (Amarillo), you may undergo procedures that will be performed at Advanced Surgical Center. The address of the Surgery Center is 1901 Medi Park Drive, Suite 01, Amarillo, TX 79106. This information is being provided to help you make an informed decision about your health care. You will not be treated differently by your physician, Advanced Pain Care or Advanced Surgical Center if you choose to use a different facility.

_____ **DURING THE COURSE OF YOUR PHYSICIAN/PATIENT RELATIONSHIP** with Advanced Pain Care, you may undergo procedures at Round Rock Surgery Center that will be performed with Neuromonitoring. You are hereby advised that Mark Malone, MD has an investment interest in Greater Texas Neuromonitoring, LLC. This information is being provided to help you make an informed decision about your health care. You will not be treated differently by your physician, Advanced Pain Care or Round Rock Surgery Center if you choose to decline Neuromonitoring.

Patient Signature: _____ Date: _____

Witness Signature:_____ Date: _____

ADVANCED PAIN CARE™
Pain Management

PAIN MANAGEMENT AGREEMENT

Patient's Name: Date of Birth:

AS REQUIRED BY THE TEXAS MEDICAL BOARD REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER *170 3 Rd Edition: Developed by the Texas Pain Society, April2008 (www.texaspain.org).*

_____**I UNDERSTAND** that this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician.

_____**I UNDERSTAND** that there are Federal and State laws, regulations and policies regarding the use and prescribing of controlled substance(s). *Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.*

_____**I UNDERSTAND** that my physician may at any time choose to discontinue medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the *medication(s) may be discontinued*.
- I will *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*.
- I agree *not to share*, sell or otherwise permit others, including my family and friends, to have access to these medications. I will *not allow or assist in the misuse*/diversion of my medication; *nor will I give or sell them* to anyone else.
- All medication(s) must be obtained at one pharmacy, where possible. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I 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) may be 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 medication(s) run out.
- I will receive medication(s) *only from ONE physician* unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that have not been approved by my physician may lead to discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), *then my physician may try alternative medication(s) or may taper me off all medication(s).* I will not hold my physician liable for problems caused by the discontinuance of medication(s).
- I *agree to submit to urine and/or blood 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), such as marijuana, speed, cocaine, etc., 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/or rehabilitation and/or cognitive behavioral therapy/psychotherapy performed by a therapist or licensed counselor.

Patient's Name: Date of Birth:

- 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 *permission* to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. *Any unauthorized increase* in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must *keep all follow-up appointments* as recommended by my physician or my treatment may be discontinued.

_____**I CERTIFY** that I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse.

_____**I AM READING AND MAKING THIS AGREEMENT** while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

_____**I CERTIFY** that I have never been involved in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

_____**I UNDERSTAND** that 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.

_____**I CONSENT** to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

_____**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.

I HAVE READ AND UNDERSTAND THIS AGREEMENT and have received a copy for my records.

Patient Signature:_____ Date:_____

Physician Signature:_____ Date:_____

ADVANCED PAIN CARE™
Pain Management

Opioid Risk Tool

Patient name: *Date of Birth:*

The Opioid Risk Tool (ORT) is a brief, self-report screening tool designed for use with adult patients to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

ASSIGNMENT OF INSURANCE BENEFITS, CONSENT FOR TREATMENT, GUARENTEE AND STATEMENT OF SERVICE

Patient's Name: Date of Birth:

I hereby assign and authorize payment made directly to **Advanced Pain Care and it's sub-specialiteis, Round Rock Surgery Center, or Advanced Surgical Center** of all of my covered health insurance benefits including Medicare, Medicaid, Medigap, HSA, commercial, all third party payors, or private managed care plans and insurance whether payable directly to me by any or all third party payors.

I UNDERSTAND my health insurance plan or third party payors may not cover part or all of the medical services rendered. *I fully understand I am financially responsible for and agree to pay all charges not paid by my health insurance plans or payors, including deductibles and co-insurance regardless of reason given for non-payment. I agree to immediately forward all payments, explanations of benefits, and correspondence sent directly to me from any and all third party payors related to care rendered by Advanced Pain Care and it's sub-specialties, Round Rock Surgery Center, or Advanced Surgical Center and agree that failure to do so will make me responsible for the entire billed charge.* My assignment of benefits covers Advanced Pain Care and it's sub-specialties, Round Rock Surgery Center, or Advanced Surgical Center physicians and surgical center for all services now rendered and to be rendered in the future until this assignment is revoked. This assignment of benefits *supersedes* any previous assignments or agreements I made with my insurance company, including Blue Cross Blue Shield and their related companies or any other third party payor to pay me directly. A copy of this form shall be considered as valid as the original. I have received a copy of Advanced Pain Care and it's sub-specialties, Round Rock Surgery Center, or Advanced Surgical Center's patient information brochure.

I UNDERSTAND Advanced Pain Care and it's sub-specialties, Round Rock Surgery Center, or Advanced Surgical Center , is a licensed surgical center and multi-specialty clinic and files claims on my behalf as a courtesy. I agree that I am financially responsible for any facility fees, laboratory test charges, and x-ray charges incurred on my behalf for care rendered. These charges will be in addition to charges for the care that the physicians at Advanced Pain Care and it's sub-specialties, Round Rock Surgery Center, or Advanced Surgical Center . I further understand I may receive separate bills for each of these services, and that I am financially responsible for any services not covered by third party payors, including but not limited to my health insurance and/or managed care plans. I acknowledge *some or all of my care*, including surgical center facility fees, laboratory testing, x-rays, CT, DEXA, MRI, and physician services may be provided by out-of-network providers, and that I am financially responsible for any increased co-pays, deductibles, and non-covered services provided on an out-of-network basis.

I HAVE DISCLOSED the names of all my health insurance plans and third party payors, including secondary plans, and I represent such health care coverage is in full force and effect at this time. I also agree to promptly notify Advanced Pain Care and it's sub-specialties, Round Rock Surgery Center, or Advanced Surgical Center , of any change in my health insurance plan and/or coverage as well as any changes in my address and phone number. I understand that my failure to do so may make me fully responsible for the *entire* bill. In consideration of the services furnished to me, I hereby agree to pay any balance due *within thirty (30) days* from presentation of my bill. If my account should become delinquent, and collection efforts become necessary, I agree to pay 1% per month delinquency charges and any reasonable collection and/or attorney fees incurred. I further agree that *TRAVIS COUNTY, TX* will be the venue for any collection efforts including small claims court and for any and all other litigation required to collect amounts due.

I UNDERSTAND it is ultimately my responsibility to obtain all required referral authorizations and/or precertifications for medical services that are required by my health insurance plan and/or third party payors. I acknowledge that this is *not* the responsibility of Advanced Pain Care and it's sub-specialties, Round Rock Surgery Center, or Advanced Surgical Center

I ALSO ACKNOWLEDGE no guarantees have been made by any employee of Advanced Pain Care and it's sub-specialties, Round Rock Surgery Center, or Advanced Surgical Center or any other party about: (1) my treatment; (2) whether it will be paid for by any third party payor(s) or health insurance plans; or (3) whether any care rendered by Advanced Pain Care and it's sub-specialties, Round Rock Surgery Center, or Advanced Surgical Center including but not limited to physician services, radiology services, and surgical center fees are in or out of network with my insurance plans.

I AGREE to fully cooperate with Advanced Pain Care and it's sub-specialties, Round Rock Surgery Center, or Advanced Surgical Center to assist in their efforts to get claims paid on my behalf but understand that ultimately I am financially responsible for, and agree to pay, and unconditionally guaranty payment, of all charges not paid by my health insurance plan or third party payors.

Patient Signature: _____ Date: _____

ADVANCED PAIN CARE
Pain Management

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: Date of Birth:

- I authorize Advanced Pain Care and it's sub-specialties to release information from my Medical Record as described in this form.
- Many of our patients allow family members to call and discuss medical information, request prescription refills, medical records, and results of tests, pick up forms, etc. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have any of your medical information released to family members you must sign this form. Signing this form will only give consent to release said information to the individuals indicated below.

Name	Relationship	Phone Number
Name	Relationship	Phone Number

Check all that apply to the above names:

___Regarding appointment, time & date
___Discuss medical care, an issue or concern
___Discuss Billing Information
___Discuss Lab Results
___Pick up Prescriptions
___Discuss Imaging Results
___Pick up Forms

RIGHT TO REVOKE: *I understand that I can withdraw at any time by giving written notice stating my intent to TERMINATE this authorization to* ***Advanced Pain Care 2000 S. Mays St., Suite 201 Round Rock, TX 78664****. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my Medical Record will not be affected.*

SIGNATURE AUTHORIZATION: *I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop release of Medical Record that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code 181.154(c) and/or 45 C.F.R. 164.502(a)(1). I understand that information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.*

Patient Signature	Date
Legally Authorized Representative	Relationship to Patient
Witness	Date

FINANCIAL POLICY

Patient's Name: Date of Birth:

Thank you for choosing **Advanced Pain Care and it's sub-specialties, Round Rock Surgery Center, or Advanced Surgical Center** as your health care provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask our business office personnel. We ask that all patients read and sign our Financial Policy prior to seeing a medical care provider.

Patient's portion of payment, including co-pay, deductible, and/or balance on account is due at the time services are rendered unless prior arrangements have been made with the Billing Department.

We accept assignment with most major insurance companies and participating provider plans. However, you must understand that:
(Please initial all lines below)

_____1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance carrier. We verify your benefits as a courtesy and do not guarantee of coverage or payment.

_____2. All charges are your responsibility whether your insurance company pays or not.

_____3. Fees for services, along with unpaid deductibles and co-payments, are due at the time of treatment.

_____4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.

_____5. Returned checks will be subject to a $25.00 collection charge. If the check is not picked up within 10 days, the check may be turned over to law enforcement.

_____6. No show or cancellations without 24 hour notice are subject to a $25.00 charge.

_____7. Unpaid balances over 90 days may be subject to collections via small claims court, attorney, and/or collection agency with applicable collection fees. All collection fees are the responsibility of the patient.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Authorization to Release and Assign Insurance Benefits: I authorize release of **ANY** medical information, including substance abuse, mental health, and HIV/AIDS records, required to act on **ANY** medical insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to **Advanced Pain Care and it's sub-specialties, Round Rock Surgery Center, or Advanced Surgical Center** the medical and/or surgical benefits I am entitled from my insurance company(s) and/or Medicare and Medicaid. This authorization is in effect for all future claims, until I choose to revoke it in writing.

I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my medical treatment. I have had the opportunity to ask and have my questions answered to my satisfaction.

Patient Signature_____ Date: _____

Relationship to patient if not patient _____ Authorized Witness:_____

***Mark Malone MD PA includes* Advanced Pain Care and it's sub-specialties, Round Rock Surgery Center, or Advanced Surgical Center.**

NOTICE OF PRIVACY PRACTICES AND PATIENT CONSENT

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient name: *Date of Birth:*

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain PATIENT RIGHTS regarding my protected health information.

I understand that Advanced Pain Care and it's sub-speciality, Round Rock Surgery Center, and Advanced Surgical Center may use or disclose my protected health information for treatment, payment, or health care operations- which means for: providing health care to me, the patient; handling billing and payment; and taking care of other health care operations. Unless required by law, there will be no other uses or disclosures of this information without my authorization.

I authorize Advanced Pain Care and it's sub-speciality, Round Rock Surgery Center, and Advanced Surgical Center to communicate with my **PCP** *(Primary Care Physician)* **: Dr.**_____
Phone #: (_____)_____

Advanced Pain Care and it's sub-speciality, Round Rock Surgery Center, and Advanced Surgical Centerhas a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the ***'Notice of Privacy Practices'*** before signing this agreement. If I ask, Advanced Pain Care and it's sub-speciality, Round Rock Surgery Center, and Advanced Surgical Centerwill provide me with most current ***'Notice of Privacy Practices'.***

My signature below indicates that I have been given the chance to review such copy of the ***'Notice of Privacy Practices'.*** My signature means that I agree to allow Advanced Pain Care and it's sub-speciality, Round Rock Surgery Center, and Advanced Surgical Centerto use and disclose my protected health information to carry out treatment, payment and health care operations. I have the right to revoke the consent in writing at any time, except to the extent that Advanced Pain Care and it's sub-speciality, Round Rock Surgery Center, and Advanced Surgical Center has taken action relying on this consent.

_____ _____

Patient Signature ***Date***

_____ _____

Relationship to Patient if signed by another party ***Date***

You may obtain a copy of our ***'Notice of Privacy Practices'*** including any revisions to our ***'Notice of Privacy Practices'*** at any time by contacting: Advanced Pain Care and it's sub-speciality, Round Rock Surgery Center, and Advanced Surgical Center at 2000 S. Mays St, Round Rock Texas 78664 or (512) 244-4272.

****** OFFICE USE ONLY ******

Staff initial below when completed

Consent dates have been updated in Centricity _____

Meaningful Use: Demographics

Patient Name: **DOB:**

Language

English

Spanish

Other:_____

Race

American Indian or Alaskan Native

Asian

Chinese

Filipino

Japanese

Black or African American

White or Caucasian

Native Hawaiian

Multi-Racial

Other:_____

Ethnicity

Hispanic or Latino

Non-Hispanic or Latino

Portal Email

Please provide email for patient portal access: _____

_____ _____

Patient Signature *Date*

**** OFFICE USE ONLY ****

Staff initial below when completed

Race / Ethnicity / Language updated in Centricity _____

Portal Registration: Y or N If No, did you print portal letter? Y or N _____

ADVANCED PAIN CARE
Pain Management

Authorization to Release Medical Records

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the release of your Medical Records.

Patient Name: DOB:

Phone Number: Email Address:

RELEASE INFO TO:

Name:_____

Address:_____

City, State:_____ Zip:_____

Phone: _____

Fax: _____

OBTAIN INFO FROM:

Name:_____

Address:_____

City, State:_____ Zip:_____

Phone: _____

Fax: _____

Reason for Disclosure (Please circle one):

Treatment/Continuing Care | Personal Use | Billing/Claims

Insurance | Legal Purposes | Disability Determination

School | Unemployment | Other: _____

What information can be disclosed? *Complete the following by indicating those items that you want disclosed. If entire Medical Record is to be released, then check only the first line.*

___**Entire Record** ___History/Physical Exam ___Past/Present Medication ___Lab Results

___Physicians Orders ___Patient Allergies ___Operation Reports ___Consultations

___Progress Notes ___Diagnostic Test Reports ___Billing Information ___Radiology

Your initials are required to <u>NOT</u> release the following information:

___Mental Health Records (Excluding Psychotherapy Notes) ___Genetic Information/results

___Drug, Alcohol, or Substance Abuse Records ___ HIV/AIDS test results/treatment

RIGHT TO REVOKE: *I understand that I can withdraw at any time by giving written notice stating my intent to TERMINATE this authorization to **<u>Advanced Pain Care 2000 S. Mays St., Suite 201 Round Rock, TX 78664</u>**. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my Medical Record will not be affected.*

SIGNATURE AUTHORIZATION: *I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop release of Medical Record that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code 181.154(c) and/or 45 C.F.R. 164.502(a)(1). I understand that information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.*

_____ _____

Patient Signature Date

_____ _____

Legally Authorized Representative Relationship to Patient

_____ _____

Witness Signature Date