

## Rheumatology New Patient Intake

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Reason for Visit / Chief Complaint:** \_\_\_\_\_

**Primary Care:** \_\_\_\_\_

**SOCIAL HISTORY:**

Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Widower \_\_\_ Separated \_\_\_ Divorced \_\_\_ Life partner

Current Occupation: \_\_\_\_\_

\_\_\_ Unemployed \_\_\_ Sedentary \_\_\_ Moderate activity \_\_\_ Laborer

Past Occupation: \_\_\_\_\_ Notes: \_\_\_\_\_

 Lifestyle/Habits: \_\_\_ Alcohol Use \_\_\_ IV drug use \_\_\_ Other drug use \_\_\_ Tattoos  
 \_\_\_ History of blood transfusion \_\_\_ Tobacco Use: \_\_\_ packs/day for \_\_\_ years

List Allergies: \_\_\_\_\_

Past Surgical History: \_\_\_\_\_

Imaging: \_\_\_\_\_

Date: \_\_\_ / \_\_\_ / \_\_\_ Where? \_\_\_\_\_

**CURRENT MEDICATIONS:**

<i>Drug Name</i>	<i>Dose</i>	<i>Directions</i>

 Preferred Pharmacy:  Advanced Rx  Other: \_\_\_\_\_

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

Reviewed by physician \_\_\_\_\_ Date \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**RHEUMATOLOGY/ARTHRITIS FAMILY HISTORY** (Name the conditions if known)

\_\_\_ Mother \_\_\_\_\_                      \_\_\_ Father \_\_\_\_\_  
 \_\_\_ Sister \_\_\_\_\_                      \_\_\_ Brother \_\_\_\_\_  
 \_\_\_ Other \_\_\_\_\_

**PAST MEDICAL HISTORY**

✓**CHECK**, if your doctor diagnosed you with any of the following conditions:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Acid Reflux/GERD              | <input type="checkbox"/> Emphysema                   | <input type="checkbox"/> PE (blood clots in the lungs) |
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Headaches/migraines         | <input type="checkbox"/> Pneumonia                     |
| <input type="checkbox"/> Anxiety                       | <input type="checkbox"/> Heart attack, heart disease | <input type="checkbox"/> Psoriasis                     |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> High blood pressure         | <input type="checkbox"/> Seizure                       |
| <input type="checkbox"/> Bowel disease                 | <input type="checkbox"/> High cholesterol            | <input type="checkbox"/> Sinusitis                     |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> HIV/AIDS                    | <input type="checkbox"/> Sleep problems/sleep apnea    |
| <input type="checkbox"/> Depression                    | <input type="checkbox"/> Kidney disease              | <input type="checkbox"/> Stomach ulcers/bleeding       |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Liver disease               | <input type="checkbox"/> Stroke/mini-stroke            |
| <input type="checkbox"/> DVT (blood clots in the legs) | <input type="checkbox"/> Miscarriage                 | <input type="checkbox"/> Thyroid disease               |
|  |  | <input type="checkbox"/> Tuberculosis                  |

**PATIENT RHEUMATOLIC HISTORY:**

✓**CHECK**, any of the following rheumatologic diseases that you have been diagnosed with in the past:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Antiphospholipid (APS) | <input type="checkbox"/> Lupus                      | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Avascular necrosis     | <input type="checkbox"/> Osteoarthritis             | <input type="checkbox"/> Scleroderma          |
| <input type="checkbox"/> Bursitis               | <input type="checkbox"/> Osteoporosis               | <input type="checkbox"/> Sjogren's syndrome   |
| <input type="checkbox"/> Dermatomyositis        | <input type="checkbox"/> Periph Nerve-carpal tunnel | <input type="checkbox"/> Tendonitis           |
| <input type="checkbox"/> Fibromyalgia           | <input type="checkbox"/> Periph Nerve-tarsal tunnel | <input type="checkbox"/> Vasculitis           |
| <input type="checkbox"/> Fracture, vertebral    | <input type="checkbox"/> Polymyalgia Rheumatica     | <input type="checkbox"/> Other: _____         |
| <input type="checkbox"/> Fracture, other        | <input type="checkbox"/> Polymyositis               | <input type="checkbox"/> <b>NONE</b>          |
| <input type="checkbox"/> Gout                   | <input type="checkbox"/> Pseudogout                 |   |

Reviewed by physician \_\_\_\_\_ Date \_\_\_\_\_

**Patient Name:**

**Date of Birth:**

**REVIEW OF SYSTEMS:**

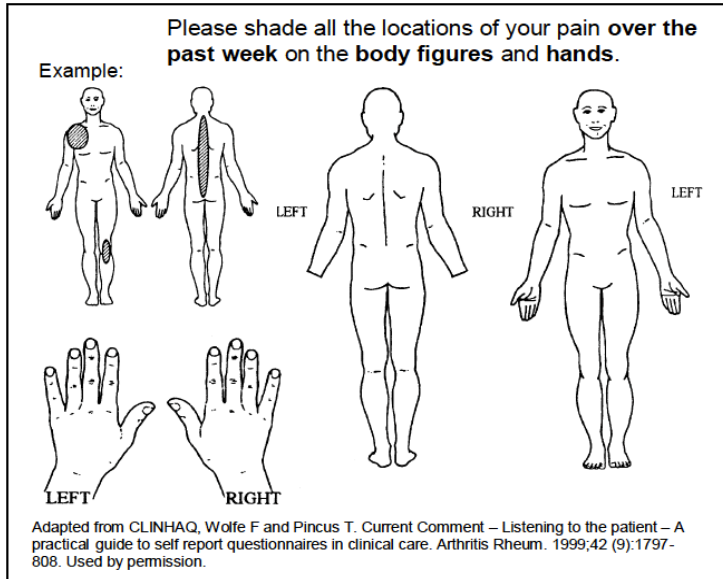
Do you have problems with any of the symptoms listed below? ✓**CHECK** yes or no

	Y	N		Y	N		Y	N
<b>GENERAL</b>			<b>GENITAL/URINARY TRACK</b>			<b>NERVOUS SYSTEM</b>		
Chills			Discharge			Bowel/bladder control		
Fatigue/tiredness			Painful urination			Headache		
Fevers			Frequency			Numbness/tingling		
Night sweats			Genital ulcer			Other		
Sleep disturbances			Blood in urine			<b>OB/GYN</b>		
Weight gain			Testicular pain			Abnormal menses		
Weight loss			Other			Menopause		
Other			<b>EYES/EARS/NOSE/THROAT</b>			Other		
<b>ALLERGY</b>			Diminished vision			<b>LUNGS</b>		
Seasonal			Eye pain			Cough		
Other			Dry eyes			Coughing blood		
<b>HEART</b>			Red eyes			Shortness of breath		
Chest pain			TMJ symptoms			Other		
Leg swelling			Dry mouth			<b>SKIN</b>		
Palpitation			Oral ulcers			Hair loss		
Other			Parotid gland swelling			Bruising		
<b>HORMONE PROBLEMS</b>			Imbalance			Sun-sensitive skin rash		
Thyroid			Hearing loss			Rash		
Other			Other			Raynaud's		
<b>STOMACH/BOWEL</b>			<b>BLOOD DISORDERS</b>			Skin ulcer		
Anorexia			Bleeding problems			Other		
Bloody/tarry stools			Blood transfusion history			<b>PSYCHIATRIC</b>		
Constipation			Other			Depression		
Diarrhea			<b>MUSCULOSKELETAL</b>			Anxiety		
Heartburn			Joint pain			Other		
Jaundice			Joint swelling			<b>NOTES:</b>		
Stomach upset			Muscle weakness					
Nausea			Morning stiffness > 1 hour (If "Y" hrs: mins)					
Vomiting			Muscle pain					
Other			Other					

Reviewed by physician \_\_\_\_\_ Date \_\_\_\_\_

**Patient Name:**

**Date of Birth:**



**PE:**                      **N**      **A**

**Assessment:**

	<b>N</b>	<b>A</b>
<b>GEN</b>		
<b>HEENT</b>		
<b>RESP</b>		
<b>CVS</b>		
<b>ABD</b>		
<b>MSK</b>		
Gait		
Shoulder		
Elbow		
Wrist		
Hand		
Hips		
Knee		
Ankles		
Feet		
Spine		

**Plan:**

Reviewed by physician \_\_\_\_\_ Date \_\_\_\_\_

## 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, April 2008 ([www.texaspain.org](http://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: \_\_\_\_\_

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## 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: \_\_\_\_\_



## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

- I authorize Advanced Pain Care and its 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:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Regarding appointment, time & date        | <input type="checkbox"/> Discuss Lab Results   | <input type="checkbox"/> Discuss Imaging Results |
| <input type="checkbox"/> Discuss medical care, an issue or concern | <input type="checkbox"/> Pick up Prescriptions | <input type="checkbox"/> Pick up Forms           |
| <input type="checkbox"/> Discuss Billing Information               |  |  |

**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 its 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 its 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 its 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 its 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 its sub-speciality, Round Rock Surgery Center, and Advanced Surgical Center to communicate with my **PCP (Primary Care Physician) : Dr.** \_\_\_\_\_

Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Advanced Pain Care and its sub-speciality, Round Rock Surgery Center, and Advanced Surgical Center has 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 its sub-speciality, Round Rock Surgery Center, and Advanced Surgical Center will 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 its sub-speciality, Round Rock Surgery Center, and Advanced Surgical Center to 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 its 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 its 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 \_\_\_\_\_



## 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:  
Phone Number:

DOB:  
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.

<input type="checkbox"/> <b>Entire Record</b>	<input type="checkbox"/> History/Physical Exam	<input type="checkbox"/> Past/Present Medication	<input type="checkbox"/> Lab Results
<input type="checkbox"/> Physicians Orders	<input type="checkbox"/> Patient Allergies	<input type="checkbox"/> Operation Reports	<input type="checkbox"/> Consultations
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Diagnostic Test Reports	<input type="checkbox"/> Billing Information	<input type="checkbox"/> Radiology

### Your initials are required to **NOT** release the following information:

<input type="checkbox"/> Mental Health Records (Excluding Psychotherapy Notes)	<input type="checkbox"/> Genetic Information/results
<input type="checkbox"/> Drug, Alcohol, or Substance Abuse Records	<input type="checkbox"/> 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 **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 Signature

\_\_\_\_\_  
Date