ADVANCED PAIN CARE

OPIOID STEWARDSHIP NEW PATIENT INTAKE

Patient Name: _____ **DOB:** _____

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

Were you referred to our office? ☐Yes | ☐No If yes, by who? _____

Past Psychiatric History

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

When	By Whom	Nature of Treatment

Past 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 currently? 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

ADVANCED PAIN CARE

OPIOID STEWARDSHIP NEW PATIENT INTAKE

Patient Name: _____ **DOB:** _____

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, and/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, and/or possession of controlled substance? ☐ Yes | ☐ No

Any tobacco use? ☐ Yes | ☐ No | ☐ Prior Use

If yes, packs per day _____ for _____ years. If prior user, year quit? _____

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

ADVANCED PAIN CARE

OPIOID STEWARDSHIP NEW PATIENT INTAKE

Patient Name: _____ **DOB:** _____

Allergies (Please list all medication/drug allergies with the reaction):

Name of Medication:	Reaction:

Current Medication (Please list all the medications you are currently taking):

Name of Medication	Dose	Directions	What is it for	Who prescribes it

Preferred Pharmacy: ☐ Advanced Rx ☐ Other: _____

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

Please Provider Your Past Medical Conditions/Diagnosis

Condition/Diagnosis	Details	Treating Physician

ADVANCED PAIN CARE

OPIOID STEWARDSHIP NEW PATIENT INTAKE

Patient Name: _____ **DOB:** _____

Please Provider Your Past Surgical History

Date of Surgery	Type of Surgery	Hospital	Performed By

Hospitalization other than surgery (include dates): _____

Family Medical 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: _____

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

ADVANCED PAIN CARE

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:_____

ADVANCED PAIN CARE

ASSIGNMENT OF BENEFITS (AOB), RELEASE OF INFORMATION (ROI) AND FINANCIAL AGREEMENT

Patient's Name: _____ Date of Birth: _____

Thank you for choosing **Advanced Pain Care and its sub-specialties, affiliated and related entities** 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.

A 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:

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 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. Office visit no shows without 24-hour notice, are subject to a $25.00 charge.
7. Paperwork requiring completion by a provider will incur a $75.00 charge. Including but limited to disability, FMLA, etc.
8. Unpaid balances over 90 days may be subject to collection 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 about any such problems so that we can assist you in the management of your account.

Procedure No Show, Cancellations & Reschedules within 72 hours:
At the time of scheduling, a credit card will be obtained and securely placed on file. Failure to show on the scheduled day, or cancellation or rescheduling made within 72 hours of the procedure, will incur a $75 fee.

Authorization to Release Billing Information and Assignment of 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, affiliated and related entities** 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 _____

Mark Malone MD PA includes Advanced Pain Care and sub-specialties, affiliated and related entities.

ADVANCED PAIN CARE

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 with respect to my protected health information.

I understand that Advanced Pain Care and its subspecialty, Advanced Surgical Center , may use or disclose my protected health information for treatment, payment, or health care operations, which means: providing health care to me, the patient; managing billing and payment; and handling other health care operations. Except as required by law, there will be no other uses or disclosures of this information without my permission.

I authorize Advanced Pain Care and its Subspecialty, Advanced Surgical Center to communicate with me **PCP** *(Primary Care Physician)***: Dr.**_____ Phone #: ( ) _____

Advanced Pain Care and its subspecialty, Advanced Surgical Center, have a detailed document called a ***'Notice of Privacy Practices'***. It contains a more complete description of your privacy rights 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 subspecialty, Advanced Surgical Center, will provide me with most of ***the current 'Privacy Consultations'.***

My signature below indicates that I have been given the opportunity to review such a copy of the ***'Notice of Privacy Practices'.*** My signature signifies that I agree to allow Advanced Pain Care and its subspecialty, Advanced Surgical Center , to use and disclose my protected health information to carry out treatments, payments, and health care operations. I have the right to revoke consent in writing at any time, except to the extent that Advanced Pain Care and its subspecialty, Advanced Surgical Center , have taken action based on this consent.

_____ _____

Patient's signature ***Date***

_____ _____

Patient Relationship 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 subspecialty, Advanced Surgical Center at 2000 S. Mays St, Round Rock, Texas 78664 or (512) 244-4272.

OFFICE USE ONLY ****

Staff initials below when completed

Consent dates have been updated in Athena _____

ADVANCED PAIN CARE

INFORMED CONSENT - PAIN MANAGEMENT AND ADDICTIONOLOGY

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 READ AND SIGN THE BOTTOM OF THE FORM 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.

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.

ADVANCED PAIN CARE

INFORMED CONSENT - PAIN MANAGEMENT AND ADDICTIONOLOGY

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

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.

FOR FEMALE PATIENTS ONLY:

1. 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.
2. I accept that it is **MY RESPONSIBILITY** to inform my physician immediately if I become pregnant.
3. If I am pregnant or am uncertain, **I WILL NOTIFY MY PHYSICIAN IMMEDIATELY**. All 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 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.

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 Advanced Surgical 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 Advanced Surgery Center if you choose to use a different facility.

DURING THE COURSE OF YOUR PHYSICIAN/PATIENT RELATIONSHIP with Advanced Pain Care (Killeen Area), you may undergo procedures that will be performed at Advanced Surgical 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 Advanced 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 Advanced Surgical 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 Advanced Surgery Center if you choose to decline Neuromonitoring.

ARTIFICIAL INTELLIGENCE (AI) DOCUMENTATION NOTICE: Our practice uses artificial intelligence (AI) technology within our electronic health record (EHR) system to assist with administrative and clinical documentation, including the dictation and transcription of office visits.

Patient Signature:_____ **Date:**_____

Witness Signature:_____ **Date:**_____

ADVANCED PAIN CARE

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

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:

Failure to designate any limitations on the release of PHI below shall result in authorization to release all medical records.

- ☐ 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. I understand that Advanced Pain Care will not condition treatment on whether I sign this authorization.*

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.*

This authorization will expire in 1 year from the date of signature unless another date is specified: _____

Patient Signature	Date
Legally Authorized Representative	Relationship to Patient

ADVANCED PAIN CARE

Quality: 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

Marital Status

☐ Married ☐ Single
☐ Widowed ☐ Partner

Portal Email

Please provide email for patient portal access: _____

Consent to Text, Call and leave detailed voice messages

Do you give Advanced Pain Care permission to text you? ☐ Yes ☐ No

Do you give Advanced Pain Care permission to call you? ☐ Yes ☐ No

Consent for communication of medical information via voice message

Do you give Advanced Pain Care permission to leave a detailed voice message on your phone regarding your healthcare? This may include but is not limited to information about upcoming surgical procedures, appointment information, payment information, lab results, and other health-related information. ☐ Yes ☐ No

_____ _____

Patient Signature *Date*

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

Staff initial below when completed

Race / Ethnicity / Language updated in Athena _____

Portal Registration: Y or N If no, did they decline and you printed portal URL? Y or N _____

ADVANCED PAIN CARE

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

Notice Informing Individuals About Nondiscrimination and Accessibility

Discrimination is Against the Law

Advanced Pain Care/Advanced Surgical/Advanced Pharmacies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)) [optional: (or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Advanced Pain Care/Advanced Surgical/Advanced Pharmacies does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Advanced Pain Care/Advanced Surgical/Advanced Pharmacies:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Michael Jensen, Compliance Officer and Civil Rights Coordinator.

If you believe that Advanced Pain Care/Advanced Surgical/Advanced Pharmacies has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Michael Jensen, Compliance Officer and Civil Rights Coordinator, 101 Louis Henna Blvd., Ste 300, Austin, TX 78278, Tel: 512-244-4272, Fax: 512-244-2895, or at compliance@advancedpaincare.us.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Michael Jensen, Compliance Officer and Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at Advanced Pain Care's website: https://austinpaindoctor.com

By signing below, I acknowledge that I have been given this notice.

Patient Signature: _____ **Date:** _____