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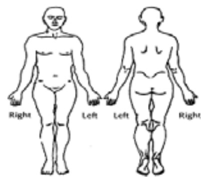
New Patient Intake

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

Date of Visit:____ **Location of Care**: ___________________

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



Please shade where it hurts

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 pain: 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**: ______________________

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

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:____

____

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:____

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

Review of Systems

	Y	N		Y	N		Y	N
GENERAL			**GASTROINTESTINAL**			**HEENT**		
Decreased Appetite			Nausea / Vomiting			Blind Field of Vision		
Unexpected Weight Loss			Abdominal Pain			Cataracts		
Unexpected Weight Gain			Irregular Bowel Habits			Hearing Loss / Ringing		
Fatigue			Loss of Control of Bowels			Sore Throat / Hoarseness		
Fever or Chills			Jaundice			Other		
Other			Gallstones			**MUSCOLOSKELETAL**		
NEURO			Hepatitis			Joint Pain / Arthritis		
Headache			Cirrhosis			Back Pain		
Strokes / CVA			Fluid In Abdomen			Neck Pain		
Seizures			Pancreatitis			Muscle Aching		
Other			Other			Other		
RENAL/URINARY			**CARDIOVASCULAR**			**PSYCH**		
Renal Failure/Insufficiency			Chest Pain			Drug Abuse / Addiction		
Electrolyte Disturbances			Coronary Artery Disease			Depression		
Kidney Stones			High Blood Pressure			Anxiety		
Difficulty Urinating			Swelling In Feet			Suicide Attempt		
UTI			Abnormal Headaches			Other		
Prostate Cancer			Other					
Other			**BLOOD/LYMPH**					
RESPIRATORY			Anemia					
Sleep Apnea			HIV					
Complications with Sedation			Bruise Easily					
Chronic Bronchitis			Past Blood Transfusion					
Difficult Breathing			Swollen / Tender Lymph Nodes					
Persistent Coughing			Cancer					
Asthma			Other					
Other			**ENDOCRINE**					
SKIN			Diabetes					
Rash			Thyroid Problems					
Itching			Osteoporosis					
Unusual Hair			Other					

Patient Signature:______________________________**Employee's Initials**:_________**Provider's Initials**:__________

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INFORMED CONSENT

Patient 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.

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 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 if you chose. 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 Mark Malone, MD and Ryan Michaud, MD have 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. You are hereby advised that Mark Malone, 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 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 or Advanced Surgical 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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PAIN MANAGEMENT AGREEMENT

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)*

Patient Name: ____ **Date of Birth:** ____________________________

PLEASE INITIAL EACH PARAGRAPH SIGNIFYING CONSENT AND UNDERSTANDING

__________**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 the 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) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) *only from ONE physician* 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 has not been approved by my physician may lead to a 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).

Patient Name: ____ **Date of Birth:** ___________________________

- 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 rehabilitation and/or cognitive behavioral therapy/psychotherapy.
- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize that my *active participation in the management of my pain* is extremely important. I agree to *actively participate in all aspects of the pain management program* recommended by my physician to achieve increased function and improved quality of life.
- I agree that I *shall inform any doctor* who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician *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:________________

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

Patient Name: ______________________________ **Date of Birth:**__________________

I hereby assign and authorize payment made directly to **Advanced Pain Care, 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, Advanced Rheumatology Care, 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, Advanced Rheumatology Care, Advanced Addictionology Care, 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, Advanced Rheumatology Care, or Round Rock Surgery Center's patient information brochure.

I UNDERSTAND Advanced Pain Care, Advanced Rheumatology Care, Advanced Addictionology Care, 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, Advanced Rheumatology Care, or Round Rock Surgery Center provide. 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, Advanced Rheumatology Care, Advanced Addictionology Care,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, Advanced Rheumatology Care, Advanced Addictionology Care, Round Rock Surgery Center, or Advanced Surgical Center.

I ALSO ACKNOWLEDGE no guarantees have been made by any employee of Advanced Pain Care, Advanced Rheumatology Care, Advanced Addictionology Care, 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, Advanced Rheumatology Care, 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, Advanced Rheumatology Care, Advanced Addictionology Care,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 signed**: ____________________

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name:____ Date of Birth:________________________

- I authorize Advanced Pain Care, Round Rock Surgery Center, or Advanced Surgical Center 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- ATTN Medical Records 101 W Louis Henna Blvd, Suite 300, Austin, TX 78728**. 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

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Email and Text Messaging Informed Consent

Patient Name______________________________________ **Patient DOB**______________________

Many patients prefer the convenience of electronic mail ("e-mail") or text messaging to other forms of communication. Advanced Pain Care, Round Rock Surgery Center, and Advanced Surgical Center offers established patients the opportunity to communicate by e-mail or text messaging on weekdays during the normal business hours of 7:30 a.m. to 5:30 p.m and Saturdays from 8am-12pm E-mail and text messaging communications will not be monitored during off-hours, holidays, or Sundays.

Patients will be required to meet face-to-face with the physician BEFORE any e-mail or text messaging communications are accepted by Advanced Pain Care, Round Rock Surgery Center, or Advanced Surgical Center.

For routine matters that do not require immediate response, please feel free to e-mail or text our office staff. Please remember, however, that this form of communication is not appropriate for use in an emergency.

The following types of information may be disclosed through e-mail or text:

- Scheduling inquiries
- Non-urgent medical questions
- Billing or insurance questions

Disclosures within Advanced Pain Care, Round Rock Surgery Center, and Advanced Surgical Center Office:
Although Advanced Pain Care, Round Rock Surgery Center, Advanced Surgical Center acknowledges the conveniences of e-mail and text messaging, transmitting patient information by e-mail or text has a number of risks that you should seriously consider prior to using. These risks include, but are not limited to, the following:

- E-mail and text messaging are subject to transmission errors.
- E-mail can be immediately broadcasted worldwide and be received by many intended and unintended recipients.
- E-mail senders can easily send an e-mail to the wrong address.
- E-mail and text messaging are easier to falsify than handwritten or signed documents.
- Backup copies of e-mail and text messaging may exist even after the sender or the recipient has deleted his/her copy.
- Employers and on-line services have a right to archive and inspect e-mails and text messaging transmitted through their system.
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-mail is subject to malware, spam, phishing, and use by third parties for malicious or other purposes that can harm you.
- When communicating from work, you should be aware that some companies consider e-mail corporate property and your messages may be monitored. Even when emailing from home, you may feel access to your e-mail is not well controlled, so you should take that into consideration.

Taking into account these risks, Advanced Pain Care, Round Rock Surgery Center, and Advanced Surgical Center will use reasonable means to protect the security and confidentiality of e-mail and text messaging communications as required by HIPAA, HITECH and Texas Law. However, it is impossible for Advanced Pain Care and Advanced Rheumatology Care to guarantee the security and confidentiality of e-mail and text

Email and Text Messaging Informed Consent (Continued)

Patient Name____ **Patient DOB**_______________________

messaging communications. Should confidential information be improperly disclosed, through no fault of Advanced Pain Care and Advanced Rheumatology Care, Advanced Pain Care and Advanced Rheumatology Care will not be liable for such disclosures.

EMAIL AND TEXT MESSAGING SHOULD NOT BE USED FOR MEDICAL EMERGENCIES. IN THE EVENT OF AN EMERGENCY—CONTACT 911 IMMEDIATELY.

Should you wish to revoke this consent, revocation must be made in written form or e-mail. In either case, the revocation must be addressed to Chelsea Simon, who may be contacted at the following address or e-mail: 101 W Louis Henna Blvd, Suite 300, Austin, TX 78728 or csimon@advancedpaincare.us.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT:

I acknowledge that I have read and fully understand this consent form.

I understand the risks associated with the communication of e-mail or text messaging as set forth in this consent form.

I agree that Advanced Pain Care, Round Rock Surgery Center, and Advanced Surgical Center and Advanced Pain Care, Round Rock Surgery Center, and Advanced Surgical Center's Workforce may use e-mail or text messaging to facilitate communications with me.

Email: ____

Text Capable Number: ____

Patient Signature: ____

Witness: ____

*******SIGN BELOW IF DECLINING*******

Patient **declines** email communication: ____
Patient Signature

Patient **declines** text communications: ____
Patient Signature

Round Rock | South Austin |Central Austin| North Austin | Cedar Park |Georgetown | Waco| Killeen| Amarillo

Austin Area Phone: (512) 244-4272 | Austin Area Fax: (512) 244-2895 | www.austinpaindoctor.com
Amarillo Phone: (806) 350-7918 | Amarillo Fax: (804) 418-8982

FINANCIAL POLICY

Patient's Name: ___________________________________ Date of Birth: _________________________

Thank you for choosing **Advanced Pain Care, 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 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. Completion of forms is subject to a $25.00 charge.
_____7. No show or cancellations without 24 hour notice are subject to a $25.00 charge.
_____8. 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, Round Rock Surgery Center, and 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:________________________

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Meaningful Use: Demographics

Patient Name: ____ **Date of Birth:** ___________________________

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

____ ____________________

Patient Signature *Date*

**** **OFFICE USE ONLY** ****
Staff initial below when completed

Race / Ethnicity / Language updated in Centricity ______________

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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: ATTN Medical Records 101 W Louis Henna Blvd, Suite 300, Austin, TX 78728.</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