REGISTRATION FORM

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Today's Date: _____/_____/_____ (please print)

First Name: _____ Middle: _____

Last Name: _____

DOB: _____/_____/_____ Sex: □ M □ F Social Security:_____-_____-_____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Please list two confidential numbers we can leave message with and contact you by:

Cell Phone No: (_____)_____ Other Phone No: (_____)_____

E- Mail: _____

Referring Physician:_____Phone #:(_____)_____

Primary Care Physician: _____Phone #:(_____)_____

Cardiologist:_____Phone #:(_____)_____

Pharmacy:_____Phone #:(_____)_____

Work Status: □ Retired □ Unemployed □ Student □ Full Time □ Part Time

Patient Occupation: _____

Patient Employer: _____ Employer Phone No. (_____)_____

Name of Primary Insurance: _____

Patient's Relationship to Subscriber: □ Self □ Spouse □ Child □ Other _____

Policy #: _____ Group #: _____

Subscriber's Name: _____

Subscriber's S.S. # _____DOB: _____/_____ /_____

Name of Secondary Insurance (if applicable): _____

Patient's Relationship to Subscriber: □ Self □ Spouse □ Child □ Other _____

Policy #: _____ Group #: _____

Subscriber's Name: _____

Subscriber's S.S. # _____DOB: _____/_____ /_____

Is this a Workers' Compensation Injury? Yes No If Yes – Please see the front desk

Name of Emergency Contact: : _____

Relationship to Patient: _____ Contact Phone No.:(_____)_____

Dallas Pain Consultants provides the opportunity for patients to communicate by email. By providing an electronic mail address to Dallas Pain Consultants, the patient acknowledges that medical information may be contained in these communications. Email should never be used for emergency problems. Dallas Pain Consultants cannot guarantee the security and confidentiality of e-mail communication and will not be liable for improper disclosure of confidential information that is not caused by Dallas Pain Consultants intentional misconduct.

Initial_____

By signing below, you confirm that the information you have provided is correct and true to the best of your knowledge. It is your responsibility to inform Dallas Pain Consultants of any changes to any information above.

_____ _____

Patient's or Authorized Representatives Signature Todays Date

New Patient Health History and Pain Management Questionnaire

Name: _____ **Date:** _____
First Middle Last

Date of Birth: _____ **Age:** _____ **Gender:** □ Male □ Female **Marital Status**: □ S □ M □ D □ W

Ethnicity: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ Some Other Race □ Unspecified □ White

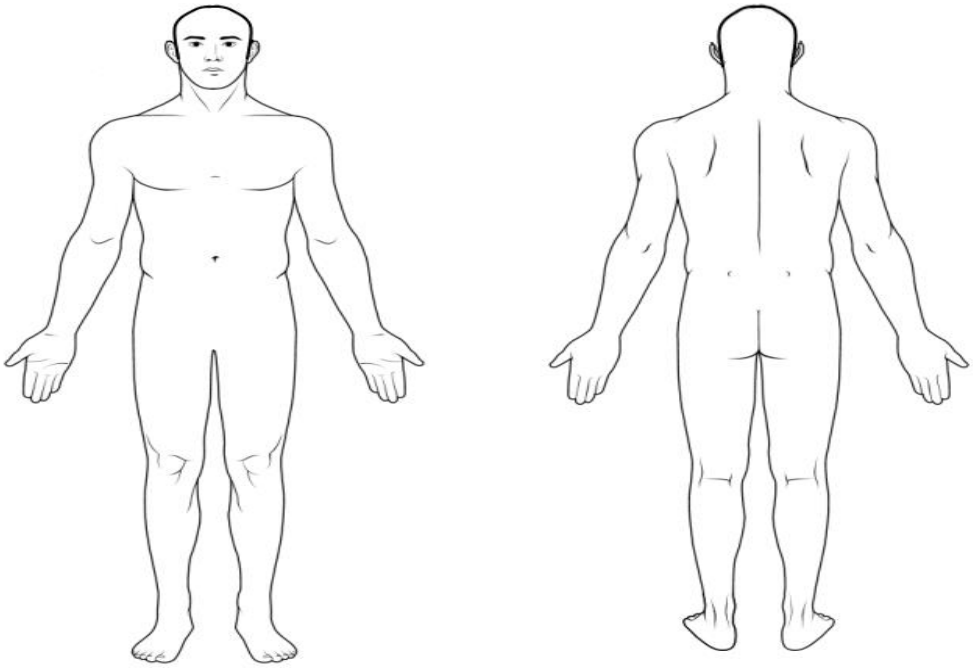
Referring Physician: _____ **Primary Care Physician** (Required):_____

Pharmacy Preference: _____ **Phone #:** _____

Date of first episode of pain: _____ **Date of Diagnosis**: _____

Under what circumstances did the pain begin?
□ Work Accident □ Home Accident □ Auto Accident □ Surgery □ Fall □ Other _____

Where is your pain? Please indicate below:



PLEASE INDICATE YOUR PAIN BY CIRCLING:

YOUR PAIN AT THE PRESENT TIME: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

YOUR PAIN AT ITS WORST: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

SINCE YOUR PAIN BEGAN IT HAS: **INCREASED** **DECREASED** **STAYED THE SAME**

Describe your pain briefly (include location of your pain):

_____

□ Aching □ Burning □ Penetrating □ Sharp □ Shooting □ Stabbing □ Throbbing

Is your pain: □ Constant □ Off and on

Do you have any of the following?
□ Numbness □ Tingling (Pins & Needles) □ Weakness □ Coldness □ Muscle Spasm □ Tightness

Does pain interfere with your sleep?
□ Occasionally □ Frequently □ Does not Affect

Aggravating factors? □ Sitting □ Standing □ Walking □ Coughing □ Bending over □ Exercise □ Lifting

□ Deep Breathing □ Lying on your back □ Other: _____

What makes the pain better?_____

Name: _____ DOB:_____

Do you take pain medication? □ YES □ NO **If yes, describe the effect:**_____
How long does the pain relief last? _____
How many times a day do you take pain medication? _____
In the past 2 weeks, have you taken more, the same or less pain medication?_____
Has the pain caused depression or other emotional problems? □ YES □ NO
If yes, have you sought medical care?_____
Has the pain affected your ability to work? □ YES □ NO **For how long?**_____
What diagnostic test(s) or treatment(s) have you had? Please indicate when and where they were done.

	Date	Location
X-ray		
MRI/CT Scan		
EMG		
Epidural Steroid Injection		
Physical Therapy		
Chiropractor/Acupuncture		
Braces/TENS unit		
Psychologist		
Comprehensive Pain Clinic		
Other_____		

List ALL your medications: (including over the counter) OR provide a current list of ALL your medications.

Medication Name	Dose	How often do you take it? (3 x day, 2 x day)

ALLERGIES: List medications to which you are allergic: □ NO KNOWN DRUG ALLERGIES

Medication	**Type of Reaction** (rash, itching, swelling, etc.)

Do you have an allergy to latex? □ Yes □ No Reaction_____
Do you have an allergy to iodine? □ Yes □ No Reaction_____
Are you currently taking anti-coagulants or blood thinners? □ Yes □ No ***(Please check all that apply)***
□ Coumadin □ Aspirin □ Plavix □ Anti-inflammatories or any others?
Who is prescribing this for you? Doctor:_____Tel #:_____

STOP! DID YOU COMPLETE YOUR HEALTH HISTORY THROUGH THE ONLINE PORTAL? □ YES □ NO
IF YES – YOU DO NOT NEED TO CONTINUE UNLESS YOU NEED TO ADD MORE EXPLANATION

Name: _____ DOB: _____

Past Medical History:
□ High blood pressure □ Sleep Apnea □ Hepatitis □ Depression □ Bi-polar disorder □ Anxiety □ Diabetes □ COPD
□ Others _____

List any <u>spine</u> surgeries with dates:

_____Date:_____

_____Date:_____

_____Date:_____

List any other past Surgeries and Hospitalizations – List ALL surgeries and hospitalizations with date:

_____Date:_____

_____Date:_____

_____Date:_____

_____Date:_____

Past Family History – List all medical conditions a family member has, had or died from:
Is your mother still living? □ Yes □ No Is your father still living? □ Yes □ No

_____

_____

_____

Social History:

Work Status: □ Employed □ Full Time □ Part Time □ Retired □ Disability □ Permanent □ Temporary
Do you drink alcohol? □ Yes □ No How many drinks per week? _____ Month? _____
Tobacco use? □ Yes □ No **Number per day of:** Cigarettes _____ Cigars_____ Chewing tobacco ____ E-cig _____
What year did you start? _____ What year did you quit? _____
Do you use recreational drugs? □ Yes □ No If yes, what type and when was your last use?_____
Have you ever been treated for alcohol dependence or addiction? □ Yes □ No
Have you ever been treated for drug dependence or addiction? □ Yes □ No

Systems Review: Check any of the following which you have had in the **last 3 months or currently** have:
Cardiac:
□ Chest pain □ Varicose veins □ Irregular pulse □ Swollen ankles □ High blood pressure □ Pacemaker
Respiratory: □ Cough □ Shortness of Breath □ Asthma/wheezing □ Sleep Apnea
Gastrointestinal: □ Abdominal pain □ Constipation □ Heartburn □ Nausea □ Vomiting □ Bloody or tarry stools
□ Urinary: Blood in urine □ Kidney stones □ Kidney failure
Musculoskeletal: □ Back pain □ Neck pain □ Aching joints □ Weakness □ Bone fracture □ Muscle pain
Neurologic: □ Headache □ Weakness □ Numbness □ Tingling □ Seizures □ Tremor □ Loss of control of stool
□ Loss of urinary control
Psychiatric: □ Depression □ Bi-polar disorder □ ADHD/ADD □ Memory Loss □ Anxiety □ Sleeping difficulty
Endocrine: □ Heat intolerance □ Cold intolerance □ Frequent thirst □ Frequent urination
General: □ Fatigue □ Fever or chills_____
Nutritional: □ Unexplained weight loss

Immunizations:
Have you had the flu vaccine? □ Yes □ No When? _____
Have you had the pneumonia vaccine? □ Yes □ No When? _____
Are your vaccines up to date? □ Yes □ No

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Name:_____ DOB:_____

Financial Policy & Assignment of Benefits

Our financial policy outlines our practice guidelines which should allow you to receive all the benefits offered to you by your health plan. We ask that you read the following carefully and agree to our terms and conditions to which are necessary to facilitate your care.

- Insurance cards should be available upon request at all visits.
- We file claims as a courtesy to our patients and are only responsible for filing claims to contracted insurance companies and the member.
- Any dispute for unpaid charges from the insurance company will be billed to you the patient.
- **All copays, coinsurance & deductibles must be paid at the time of service, this is an insurance requirement and part of your contract with the insurance company.**
- **Contract –** Your insurance policy is a contract between you, your employer (if applicable) and the insurance company. We are not a party to that contract. It is important that you understand the provisions of your policy, as we cannot guarantee payment of claims. In the instance your insurance company denies payment for services provided you are responsible for payment of treatment
- **Procedures & Injections Costs –** In all cases we collect an **estimate** of your financial responsibility amount at the time of service. Procedures & injections may be rescheduled if the estimated amount is not paid on or prior to the time of service. This will be an estimate ONLY and may be subject to change depending on the services provided. We will either bill you for the remaining balance or credit any overpayment in a timely manner. Payment plans are available upon request, please contact us PRIOR to your appointment. Unless you make prior arrangements, our financial policy will stand.

Charges and Fees

- **Charges for Forms -** Our charge for completing FMLA, Disability or Life Insurance paperwork is $35.00 per form and is due in full before the paperwork can be picked up, faxed or mailed. Allow 7-10 days processing. **No Show Fees -** We require 24-hour notice for appointment cancellations. In the event you do not give the required notification a no-show fee will be assessed. Office visits will incur a $25.00 fee and procedures/injections will incur a $100.00 fee. Patients who habitually fail to keep appointments may be discharged from our clinic.
- **Returned Checks -** A $25.00 fee will be charged for any returned checks and we will no longer accept your checks.
- **Payment Methods –** We accept cash, checks (Under $100), money orders and all major credit cards (VISA, Mastercard, Discover & American Express)
- **Account Billing Questions & Refunds –** Questions or concerns regarding your account or insurance claim can be directed to our billing department (214) 948-7700 Ext 201. If your account has a credit balance, we will issue a refund once all outstanding claims on your account have processed.

Assignment of Benefits:

Insurance is considered a method of reimbursing you the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage for the charge. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance at the time of service.

I understand that I am responsible for providing **Dallas Pain Consultants** all insurance information at the time of registration to allow for verification of benefits, and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.

Initial_____

I hereby assign all medical and /or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to **Dallas Pain Consultants.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether paid by said insurance. I hereby authorized said assignees to release all information necessary to secure payment

Initial_____

By signing below, you agree to all terms and conditions stated above, you fully understand DPC financial policy and as the patient you are ultimately responsible for all liable amounts.

X_____

Patient's or Authorized Representative's Signature Todays Date

Name:_____ DOB: _____

Consent for Use & Disclosure of Protected Health Information & the Authorization to Release Information

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I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and my plans for future care or treatment.

I understand that this information servies as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand I have the right to:

- Object to the use of my health information for directory purposes.
- Request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that the organization is not required to agree to the restrictions requested.
- Revoke this consent in writing, except to the extent that the organization has already taken the action in reliance therein.

To protect your privacy under HIPAA, we have created this consent form for releasing medical information about you, for treatment, payment, and health care operations, or to family members and other people of your choosing. This will also be used for consent to leave you detailed telephone messages at the mentioned phone numbers. Many times we have patient's family member's call requesting medical information and legally we are not allowed to release that information without the patient's written consent. The purpose of this document is to protect your privacy.

I authorize Dallas Pain Consultants (DPC) to furnish requested information from the patient's medical and other records to: (1) any insurance company or third party for purpose of obtaining payment on account of DPC, (2) the disability insurance company to expedite my claim, (3) any other person(s) or entities financially responsible for the patient's care or treatment, and (4) representatives of local, state, or federal agencies in accordance with law. Such information may include, but is not limited to, information concerning communicable disease such as Acquired Immune Deficiency Syndrome ("AIDS"). I also authorize the release of information and /or review of patient's records for purpose of conducting medical audits, utilization reviews, or quality assurance reviews.

I hereby give my permission for the release of medical information regarding appointment and questions about my condition and treatments to the following person(s):

Name:_____Relation:_____Phone:_____
□ Financial and Medical Information □ Financial Information only □ Medical Information Only

Name:_____Relation:_____Phone:_____
□ Financial and Medical Information □ Financial Information only □ Medical Information Only

Name:_____Relation:_____Phone:_____
□ Financial and Medical Information □ Financial Information only □ Medical Information Only

Do you have an Advance Directive/Living Will? □ Yes □ No

I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for the communication of my health information. **I have received a copy of Dallas Pain Consultants' Noticy of Privacy Practices.**

x_____ _____
Patient's or Authorized Representative's Signature Todays Date

Name:_____ DOB: _____

Nurse Practitioner & Physician Assistant Consent

Here at, Dallas Pain Consultants, we strive to offer you high quality medical care and give strong consideration to your wait time. We employ Advanced Practice Registered Nurses, also known as Nurse Practitioners and/or Physician Assistants to assist us in carrying out your plan of care. Nurse Practitioners and Physician Assistants have received advanced education and training in the provision of health care. They are graduates of a certified training program and licensed by the Texas State Medical Board. They can diagnose, treat and monitor routine and complex pain disorders as well as provide health maintenance care. If you are seen by one of these providers, your doctor will review your care with them as part of your treatment plan. "Supervision" does not require the constant physical presence of the supervising physician, but rather, observing the activities of accepting responsibility for the medical services provided.

I have read the above and understand that in this practice a team approach is used with my unique needs presented and reviewed by one or more physicians in the development of my plan of care. I also understand that from time to time I may be seen by any or all of the providers in this practice, including the physicians, Nurse Practitioners and Physician Assistant.

I hereby consent to the services of a Nurse Practitioner or Physician Assistant for my healthcare needs. I understand that I can refuse to see the Nurse Practitioner or Physician Assistant and request to see a physician. I understand that this may require my appointment to be rescheduled.

X_____

Patient's or Authorized Representative's Signature Today's Date

Disclosure of Physician Interest & Ownership

To better serve you, our physicians, have ownership or financial interests in various other health care providers and/or facilities. Todays medical business climate is very complicated, and physicians have little negotiation power with insurance companies. Our physicians are committed to providing high quality health care services to our patients and may refer you to one of these providers and/or facilities to receive health care items or services that he has determined you need. Their ownership interest in these often provides them a voice in administrative, clinical and operational policies. This involvement helps ensure the highest level of patient care and customer service. During a physician/patient relationship you may be referred to a provider/facility or service. I am providing this information to help you make an informed decision about your health care. However you have the right to choose your health care provider and you have the option to use a health care provider/facility/service other than the provider/facility/service to which you might be referred you. You will not be treated any differently if you choose to obtain health care from a provider/facility/service other than the provider/facility/service in which DPC Providers have an ownership or financial interest. If you require assistance we will be happy to provide information about alternative providers/facilities/services. A list of these facilities/providers is available upon request.

If you have questions, please do not hesitate to ask. We welcome you as a patient & we value our relationship with you. By signing below you acknowledge that you have read and understood this Disclosure, and that you are aware of the Physician ownership or financial interest.

X_____

Patient's or Authorized Representative's Signature Today's Date

Name:_____ DOB:_____

Pain Management Agreement

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to ensure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. Medications are intended to help reduce pain, no medication will remedy pain entirely.

1. Pain medication prescriptions are obtained from our office only.
   - Exception: If you have a surgery with another provider, dental or otherwise (i.e. directed to the emergency room) that physician may prescribe pain medicine as they deem necessary.
2. Only use **one** pharmacy, if there is a change in pharmacies you must notify us.
3. Inform your physician of all medical conditions and medications you're taking, including herbal remedies, over the counter medications and other prescribed medication.
4. You agree to allow your physician to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions if the physician deems it necessary.
5. Regular appointments will be made and will receive prescriptions for enough medication to last from appointment to appointment.
6. It is against the law to give or sell your medications to any other person.
7. Prescribed medications must be taken strictly as ordered.
8. You're responsible for keeping your pain medication in a safe and secure place. Lost or stolen medication should be reported to the police and your physician immediately. Prescriptions will not be refilled early.
9. Refills of controlled substances will only be given to the patient during regular office visit scheduled appointment. Refills will not be made at night, on weekends, or during holidays.
10. You must not use any illicit substances or alcohol. The presence of non- prescribed drug(s) and/or illicit drug(s) in the urine may result in change in your treatment plan, such as the safe discontinuation of your prescribed medications and/or termination of the doctor-patient relationship.
11. **You agree and understand that your physician reserves the right to perform periodic unannounced urine drug screening and "pill counts".** Patients will be urine drug screened at their initial visit and subject to periodic testing while under our care to make sure prescribed medication is taken correctly.
12. Do not drive or use dangerous equipment when taking pain medication.
13. It is the patients' responsibility to comply with all laws and regulations while taking these medications.
14. Understand that there may be side effects and addiction to these medications is possible. If you have a history of alcohol or drug misuse/addiction, you must notify the physician.
15. Suddenly stopping these medications could be dangerous.
16. Medication plans may be altered at any time for any reason if the provider sees fit.
17. Immediate dismissal will be invoked if unauthorized visits to any of the offices without appointments are made, and harassment of any Dallas Pain Consultants employees will be taken seriously.

I have read the agreement above and understand that if I violate any of the above conditions, my prescription may be terminated immediately and possibly result in being discharge from the clinic. Final decisions will be made by the Physicians of Dallas Pain Consultants and will be final.

I understand the above list is not complete, I will be careful to exercise with caution and common sense, asking questions where a full understanding is not met or if I feel that I may be having trouble with treatment provided.

Print Name:_____ DOB:_____

X_____

Patient's or Authorized Representative's Signature Todays Date

Name:_____ DOB: _____

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General Patient Consent for Care Form

I, the undersigned, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Dallas Pain Consultants on an outpatient / office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider, including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary.

I agree and acknowledge that Dallas Pain Consultants is not liable for the actions or omissions of, or the instructions given y the physician/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations at Dallas Pain Consultants facilities.

Telemedicine
I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultive, diagnostic, and treatment service(s) may be employed to facilitate my medical care. All electronic transmission pf data will be restricted to authorized recipients in compliance with Federal Health Insurance Portability and Accountability Act (HIPAA) and applicable state privacy laws.

To the Patient:
You have the right to discuss the treatment plan with your physician/provider about the purpose, potential risks and benefits of any tests/procedures ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Signed Consent

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

X_____

Patient's or Authorized Representative's Signature Today's Date