To: Advantage Pain Management From: _____

Fax: (210) 359-6073 Phone: _____

Thank you for choosing Advantage Pain Management, PLLC. In an effort to expedite your check-in process as a new patient, please complete the new patient forms before your appointment and either fax or bring them with you to your appointment.

Items to bring to your appointment:

1.) New Patient Forms

2.) Insurance Card(s) and Driver's License

3.) Any and all recent medical records

4.) Current Medications

Office Information:

Advantage Pain Management, PLLC
4242 East Southcross, Suite 8
San Antonio, Texas 78222
Phone: (210) 359-6000
Fax: (210) 359-6073

Again, thank you for choosing Advantage Pain Management. If you have any questions please feel free to contact our office staff. We look forward to seeing you.

☐ New Patient ☐ Updated Information

Patient Demographics

Patient Name: _____ Birth Date: _____/_____/_____
LAST FIRST MI

Social Security No: _____-_____-_____ Gender: ☐ Male ☐ Female

Address: _____
STREET ADDRESS CITY STATE ZIP

Home #: ____-____-____ Cell #: ____-____-____ Work #: ____-____-____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Preferred Language: _____

Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic
☐ Native Hawaiian / Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic or Latin Decent ☐ Not Hispanic or Latin Decent ☐ Do Not Wish to Report

Emergency Contact Information

Name: _____ Phone: ____-____-____

Release of Medical Information

(Medical Information may be released to the following individuals)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Payment Information

Form of Payment: ☐ Health Insurance ☐ Auto Insurance ☐ Workers Comp ☐ Self Pay ☐ Other

Primary Insurance:

Primary Company: _____ Insured's Name: _____

Policy #: _____ Group #: _____ Insured's Date of Birth : _____

Secondary Insurance:

Secondary Company: _____ Insured's Name: _____

Policy #: _____ Group #: _____ Insured's Date of Birth : _____

Worker's Compensation: (only complete if Worker's Comp)

Name of Carrier: _____ Insured's Name: _____

Policy #: _____ Adjuster's Name: _____ Telephone _____

Date of Injury: ____/____/____ Claim #: _____ Telephone #: _____

Self Pay Agreement

I agree to pay for medical services rendered from Advantage Pain Management, PLLC. I understand that payment arrangements must be made prior to establishing as a new patient.

Patient Signature: _____ Date: _____

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION:

I authorize Advantage Pain Management, PLLC to release any medical information requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment of my medical care.

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFIT:

I authorize the release of any medical information necessary to process any claim associated with Advantage Pain Management, PLLC with respect to my medical care. I permit a copy of this authorization to be used in the place of the original.

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment of benefits to be paid directly to Advantage Pain Management, PLLC. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits, when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment, including attorney fees.

CONSENT FOR TREATMENT:

I hereby authorize the health care providers of Advantage Pain Management, PLLC to perform a physical examination and to provide any medical treatment deemed necessary. This includes but not limited to all required medical examinations, urine screens, echocardiograms, EKG, Ultrasounds, x-rays, and/or medical / surgical procedures.

PATIENT PAYMENT RESPONSIBILITY:

I hereby agree that all applicable fees, deductibles, co-insurance, and co-payments are my responsibility and must be paid at the time services are rendered, unless payment arrangements have been made.

NOTICE OF PRIVACY PRACTICES:

Advantage Pain Management, PLLC is required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Signing below indicated acknowledgement of receipt of our office's Notice of Privacy Practices.

AUTHORIZED SIGNATURE:

I authorize that I have read this document and will comply with the policies listed above. I also understand and agree that Advantage Pain Management, PLLC reserves the right to terminate the physician/patient relationship for non-compliance with any of the above policies.

_____	_____	_____
Patient Name (Please Print)	Date	Patient Signature

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office of Advantage Pain Management, PLLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). [The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.]

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of Advantage Pain Management, PLLC reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Administrator.

With this consent, the office of Advantage Pain Management, PLLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the office of Advantage Pain Management, PLLC may mail to my home or their alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the office of Advantage Pain Management, PLLC may e-mail to my email or other alternative email any times that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office of Advantage Pain Management, PLLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting that the office of Advantage Pain Management, PLLC may use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the office of Advantage Pain Management, PLLC may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____

Print Patient's Name

_____

Print Name Legal Guardian

_____

Date

NOTICE OF PRIVACY PRACTICES

ADVANTAGE PAIN MANAGEMENT PLLC

4242 E. SOUTHCROSS, Suite 8

San Antonio, TX 78222

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart, on a computer, and/or in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Officer.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

22. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your

request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the bottom of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Jorge Lozano, Regional Manage, Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169, Dallas, TX 75202
Voice Phone (800) 368-1019 FAX (214) 767-0432 TDD (800) 537-7697]
OCRMail@hhs.gov

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.

Privacy Officer: Chris Mathis
Address: 4242 E. Southcross, Suite 8, San Antonio, TX 78222
Phone: 210-359-6000 Fax: 210-359-6073

Advantage
Pain Management

New Patient Medical Questionnaire

NAME: _____ **Birth Date:** ___/___/___ **Age:** ____
LAST FIRST MI

Primary Care Physician (PCP): _____

PCP Contact/ Office Phone #: _____

Referring Physician (if different from PCP): _____

Referring Physician Contact/ Office Phone # (if different from PCP): _____

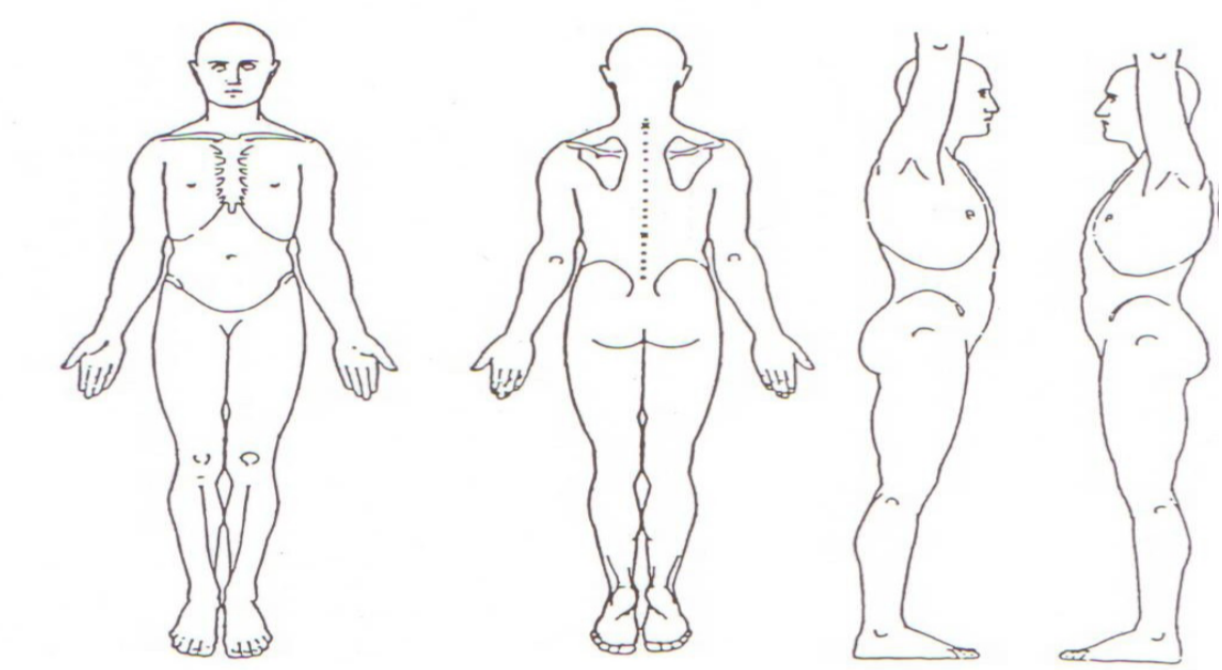
Preferred Pharmacy: _____ Phone #:_____

Allergies / Sensitivity to Medications: _____

Chief Complaint for Visit: _____

PAIN:

MARK ON THE PICTURE WHERE YOU ARE HAVING PAIN.
PLEASE MARK: (X) FOR NUMBNESS. (T) FOR TINGLING. (B) FOR BURNING.



When did the pain begin?_____

How did the pain start?

☐ Work Accident ☐ Following Surgery ☐ No Trauma ☐ Gradual Onset

☐ Home Accident ☐ Other Accident or Injury ☐ Auto Accident ☐ Unknown

Duration of Pain?

☐ Less than 1 Week ☐ 1-4 weeks ☐ 1-3 months ☐ 3-6 months ☐ less than 1 year ☐ more than 1 year ☐ many years

New Patient Medical Questionnaire

NAME: _____ Birth Date: ___/___/___ Age: ____

How often does the pain occur?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day)
☐ Intermittently (0-25% of the day) ☐ Less than Daily ☐ Weekly ☐ Monthly

Select one or more of the items below to describe the nature of your pain:

☐ Throbbing ☐ Shooting ☐ Sharp ☐ Cramping ☐ Hot/Burning ☐ Aching ☐ Stabbing ☐ Tingling ☐ Numbing ☐ Dull Ache

How do the following factors affect your pain:

	Worse	Better	No Effect
Standing	☐	☐	☐
Walking	☐	☐	☐
Sneezing	☐	☐	☐
Coughing	☐	☐	☐
Weather	☐	☐	☐
Lifting	☐	☐	☐
Lying Down	☐	☐	☐
Sitting	☐	☐	☐

Current Pain Score: _____ (0-10, 10 being the worst pain)

Check the Treatments you have had for pain:

☐ Acupuncture ☐ Physical Therapy ☐ Biofeedback ☐ Trigger Points ☐ Massage ☐ Hypnosis
☐ Exercise ☐ Psycho Therapy ☐ TENS unit ☐ Chiropractor ☐ Brace ☐ Surgery
☐ Facet Blocks ☐ Epidurals ☐ Nerve Blocks ☐ Other

Imaging Studies/Tests Done: (enter date performed)

☐ MRI __/__/__ ☐ CT Scan __/__/__ ☐ X-Rays __/__/__ ☐ EMG/NCV __/__/__ ☐ Results of TEST _____

REVIEW OF SYSTEMS (check all that apply)

Constitutional - ☐ Chills ☐ Fever ☐ Fatigue

Musculoskeletal - ☐ Numbness ☐ Weakness

Neurological - ☐ Confusion ☐ Dizziness ☐ Light Sensitivity ☐ Loss of Consciousness

Psychiatric - ☐ Suicidal thoughts ☐ Difficulty Sleeping

Cardiovascular - ☐ Chest Pain ☐ Palpitations

Respiratory - ☐ Cough ☐ Shortness of Breath

Gastrointestinal - ☐ Diarrhea ☐ Constipation ☐ Abdominal Pain ☐ Bloating ☐ Nausea ☐ Vomiting

Genitourinary - ☐ Decreased Libido ☐ Urinary Frequency

Endocrine - ☐ Easy Bruising ☐ Ringing in the Ears

PAST MEDICAL HISTORY (Check all that apply)

Constitutional ☐ Obesity ☐ Weight Loss ☐ Weight Gain

Musculoskeletal ☐ Arthritis ☐ Fibromyalgia ☐ Muscle Spasms

Neurological ☐ Headache ☐ Seizures ☐ Migraines ☐ Stroke

Psychiatric ☐ Depression ☐ Substance Abuse ☐ Anxiety ☐ Bipolar ☐Schizophrenia

Cardiovascular ☐ Angina ☐ Heart Attack ☐ Heart Stent ☐ Pacemaker ☐High Blood Pressure (Hypertension)

Respiratory ☐ Asthma ☐ Emphysema ☐ Chronic Bronchitis ☐ Lung Cancer

Gastrointestinal ☐ Reflux ☐ Hepatitis ☐ Ulcers ☐ Heartburn ☐Irritable Bowel Syndrome
☐ Cirrhosis ☐ Diverticulitis ☐ Colon Cancer

Genitourinary ☐ Impotence ☐ Kidney Stones ☐ Incontinence

Endocrine ☐ Diabetes ☐ Hypothyroidism ☐ Hyperthyroidism ☐ HIV ☐Hyperlipidemia (Elevated Cholesterol)
☐ Leukemia ☐ Lymphoma ☐ Multiple Myeloma

Rheumatologic ☐ Lupus ☐ Sjogren's ☐ Rheumatoid Arthritis ☐ Scleroderma ☐Polymyalgia Rheumatica

New Patient Medical Questionnaire

NAME: _____ Birth Date: ____/____/____ Age: _____

SOCIAL HISTORY:

Do you smoke? YES / NO How many packs per day? _____ How many Years? _____

Do you drink alcohol? YES / NO How many drinks per day? _____ How many Years? _____

Do you use illicit drugs? YES / NO How much per day? _____ Type?_____ How Many Years? _____

Family Medical History: *(Please check all that Apply)*

Conditions	Diabetes	Heart	Anxiety	Kidney	Cancer	Depression	Back	Other
Father	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐
Brother(s)	☐	☐	☐	☐	☐	☐	☐	☐
Sister (s)	☐	☐	☐	☐	☐	☐	☐	☐

Surgical / Hospital Admission History:

YEAR	TYPE OF SURGERY / ADMISSION

Medications:

List **ALL** medication that you are currently taking including Non-Prescriptions Medication & Herbal remedies *(Please DO NOT Substitute a List. Please write meds below)*

Medications	Dose	How Often	Approximately Start Date (Month/Year)

New Patient Medical Questionnaire

NAME: _____ Birth Date: _____/_____/_____ Age: _____

Past Pain Medications Tried: *(Please DO NOT Substitute a List. Please write meds below)*

Medications	Dose	How Often	Approximately Start Date (Month/Year)

FEMALE ONLY: ARE YOU PREGNANT? ☐ YES ☐ NO ☐ NOT SURE PATIENTS INITIALS _____

I ACKNOWLEGE AND AFFIRM THAT I HAVE COMPLETED THIS MEDICAL QUESTIONNAIRE ACCURATELY AND TO THE BEST OF MY KNOWLEDGE.

_____ _____/_____/_____

PATIENT OR LEGAL GUARDIAN SIGNATURE **DATE**

Advantage
Pain Management

LONG-TERM CONTROLLED SUBSTANCES THERAPY FOR CHRONIC PAIN

(A consent form from the American Academy of Pain Medicine)

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (Narcotic Analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing the relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1.) All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward interactions or poor coordination of treatment.)

2.) All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

_____ Phone: _____

3.) You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

4.) The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.

5.) **Prescriptions are to be used ONLY as written. Use of increased amount of medication, without consultation with your physician, will not be allowed.**

6.) You may not share, sell, or otherwise permit others to have access to these medications.

7.) These drugs should not be stopped abruptly, as in abstinence syndrome will likely develop.

8.) **Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.**

9.) **Long-acting narcotics will be administered for chronic pain problems. Our goal is the discontinuation of short-acting narcotics and narcotic mixtures (Percocet, Lortab, Vicodin, Norco). “Rescue Doses” of short-acting narcotics will not be routinely prescribed.**

10.) **Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.**

11.) Original containers of medications should be brought in to each office visit.

12.) Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

13.) **Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.**

14.) **Early refills will generally not be given.**

15.) Prescriptions may be issued early if the physician or patient will be out of town when refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.

16.) **If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.**

17.) It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.

18.) **Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.**

19.) It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.

20.) The risks of potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation).

21.) **Termination terms will include a written letter to you and fulfillment of your medical needs, including narcotic prescriptions, for one month after the date of termination. You will be presented with the option, in lieu of termination, to receive evaluation for drug dependency and, if appropriate, be referred for detoxification.**

Your pain is **YOUR** responsibility. Making appointments for medications refills is **YOUR** responsibility. Advantage Pain Management will provide medical support in your quest to minimize your pain. You must make new efforts to improve SLEEP HABITS, NUTRITION, BODY WEIGHT, CONDITIONING, AND PSYCHOLOGICAL STATE. Narcotics are not the answer to chronic pain, but can be used effectively to improve your pain.

You affirm that you have full right and power to sign and be bound by this agreement. You also affirm you have read, understand, and accept all of its terms.

_____	_____
Physician Signature	**Patient Signature**
_____	_____
Date	**Patient Name (Printed)**

Approved by the AAPM (The American Academy of Pain Medicine)
Executive Committee on April 2, 2001
4700 W. Lake Avenue
Glenview, IL 60020-1485
Phone#: (847)375-4731, Fax#: (877) 734-8750
E-mail:aapm@amctec.com
Web Site: www.painmed.org

Our Financial and Office Policies

Thank you for choosing Advantage Pain Management, PLLC as your healthcare provider. We are committed to providing our patients with the best available medical care. Our billing department will be available to discuss our fees and policies with you if you have any questions. We ask that all responsible parties read and signing our financial and office policies form prior to seeing the physician.

(PLEASE INITIAL BESIDE EACH SECTION INDICATING YOUR UNDERSTANDING AND ACCEPTANCE OF OUR POLICIES.)

____ 1. All co-pays, deductible, and/or co-insurances are due at the time of service. We do not choose these fees. They are provided to our office by your insurance company when we call to verify benefits and/or the terms agreed upon by you (or your employer) and your insurance company. We will collect all co-payments, deductibles or charges for non-covered services at the time upon check-in. If you have a balance on your account we will ask for that payment as well. For you convenience, we accept cash, check, Visa, Mastercard, and Discover.

____ 2. We verify insurance benefits as a courtesy to our patients. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are covered benefit in your medical plan. Some insurance companies select certain services they will not cover. Please contact your insurance company if you have any questions regarding your health care coverage. Advantage Pain Management, PLLC provides services that are medically necessary in the physician's professional opinion. If you are unsure if a procedure, immunization or injection is covered, please call your insurance company prior to receiving services. You are ultimately responsible for all charges that are not covered under your health care policy.

*Please remember that your insurance is a contract between you (or your employer) and the insurance company. We are not a party to that contract. It is very important that you understand the provisions of your healthcare policy. We cannot guarantee payment of all claims. Reduction or rejection of any claim by your insurance company does not relieve you of your obligation. In the event that your insurance company pays us for a claim that you have already paid and you are due a refund, we will be happy to expedite your refund or credit your account.

____ 3. Please ensure that all personal and insurance information is correct at any time of each visit. We will only bill the insurance company on file. It is not uncommon for someone to change their phone number or address and forget to inform us. This leads to fragmented communication. Please inform the receptionist if your address, phone number, or insurance information has changed (or if you anticipate that it will be changing in the near future).

____ 4. Some insurance companies require a referral from your primary care physician before being seen by our physicians. If your appointment requires a referral form your primary care physician, that referral will need to be on file with our office before the next appointment day. If you are seen without a referral form on file and the insurance company does not pay, you will be responsible for all charges.

____ 5. We allow 90 days for payment of any balances that are the responsibility of the patient. If we do not receive full payment in 90 days, the account may be referred to collections. We understand that temporary financial problems may affect timely payments of your balance. We encourage you to communicate any such problems to us so that we may assist you to keep your account in good standing.

____ 6. If your personal check is returned for insufficient funds, there is a $35.00 charge in addition to the amount of the check. After one instance of a returned check, all further payment will be required to be in the form of credit card, cash or money order only.

____ 7. There is a fee for copies of medical records not requested by another physician. Please ask the receptionist for an estimate if you need copies of your records. These fees are set by the Texas Medical Board not by our office.

____ 8. Regular Appointments not cancelled or rescheduled with a 24 hour advance notice and any "no show" appointments will be subjected to a charge of $25.00. Please note that this fee is not covered by your insurance company and is due prior to your next scheduled appointment. We sincerely hope that we will not need to collect this fee. Rather, it is offered as an incentive to remind all of our patients and families to keep their scheduled appointments or, if unable to keep that appointment, to please reschedule with more than a 24 hours in advance (and we greatly appreciate 48-72 hours advance notice). When you reschedule your appointment several days ahead of time, this allows other patients the opportunity to be seen sooner, which is greatly appreciate.

____ 9. Procedure Appointments not cancelled or rescheduled with a 24 hour advance notice and any "no show" procedure appointments will be subjected to a charge of $50.00. Please note that this fee is not covered by your insurance company. This fee will be due prior to the next scheduled appointment.

____ 10. If you are more than 15 minutes late for you appointment and have not called the office to inform us, we will reschedule your appointment.

____ 11. After 3 "no show" appointments we reserve the right to terminate the physician/patient relationship. A notification will be sent to the responsible party and to the referring physician.

____ 12. We require seventy-two (72) hours advance notice on all non triplicate prescription refills. You can have your pharmacy submit the refill request via facsimile. Please do not wait until you are out of medication to ask your pharmacy or our office for a refill. **All refill non triplicate prescriptions will be processed Monday through Thursday after 1 P.M. Please note that we do not process refill requests on weekends or holidays. The patient must have a follow-up appointment scheduled or have been seen within the last three (3) months in order to have any prescriptions refilled.**

____ 13. Due to Texas state laws, we have adopted the following policies regarding Triplicate prescriptions (Triplicate prescriptions are for Schedule II controlled substances): We will not mail Triplicate prescriptions. All expired Triplicate prescriptions that are not filled must be returned to our office. We require a ten (10) days advance notice call prior to pick-up of a Triplicate prescription. All Triplicate prescriptions must be filled within 21 days after the date the prescription was issued or if multiple Triplicates were issued, then the prescription must be filled within 21 days after the earliest fill date indicated.

____ 14. Please be advised if you are having someone else pick-up a prescription, we will require two (2) forms of identification. One from the person you have requested to pick up the prescription and the other form of identification from you, the patient. We will not release the prescription without these two (2) forms of identification.

Patient Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ SS#: _____-_____-_____

I hereby authorize the physician / practice (Disclosing Physician/Practice) listed below to release my Protected Health Information (information contained in my medical records) to Advantage Pain Management, PLLC.

Disclosing Physician / Practice: _____ Phone: (_____)_____-_____

Description of Information to be Disclosed:

_____ Complete Medical Record
_____ Chest X-Rays
_____ Echocardiograms
_____ Office Notes
_____ Labs Reports / Tests
_____ Nuclear Stress Test
_____ EKG Test / Results
_____ Holter Monitor Results

Protected Health Information to be Disclosed to:

Advantage Pain Management, PLLC
Attn: Medical Records
4242 East Southcross, Suite 8
San Antonio, Texas 78222
P: (210) 359-6000 F: (210) 359-6073

Purpose of Disclosure:

_____ Continuing Care
_____ Referral to Specialist
_____Change of Doctor
_____ Other: _____

I understand the following:

1). I may revoke this authorization at any time by providing written notice to Advantage Pain Management, PLLC.
2). I may not be able to revoke this authorization once the office has utilized the information received, or if the authorization was obtained as a condition of obtaining insurance coverage.
3). Advantage Pain Management, PLLC will not condition treatment or payment based upon my signing of this authorization.
4). The information disclosed by this authorization may be subject to re-disclosure by Advantage Pain Management, PLLC and no longer protected by Federal Law.
5). I authorize the release of any records related to or regarding drug, alcohol, and or mental health treatment.
6). I have reviewed this Authorization and understand it's purpose and intent
7). This Authorization is valid until or unless I submit in writing a request of revocation to the practice.

_____ _____ _____
Patient Signature Date Name (if other than Patient)