COMPREHENSIVE
Pain Solutions
of Texas

www.PainSolutionsTX.com
1300 Medical Ave., Ste. 102
Plano, TX 75075
Office: (972) 598-9900
Fax: (972) 599-0742

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received from my medical provider a copy of a separate document, entitled, “Notice of Privacy Practices” which sets forth this provider's privacy practices and my rights regarding privacy of my protected health information.

Print Name _____ Date _____

Signature _____

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:
Full Name: _____
Other Name(s) Used: _____ Date of Birth: _____
Address:_____ City:_____ State:_____ Zip Code:_____
Phone: (_____)_____ Email (*Optional*): _____

Information regarding health care provider or health care entity authorized to disclose this information:
Name: _____
Address:_____City:_____ State:_____ Zip Code:_____
Phone: (_____)_____ Fax: (_____)_____

Information regarding person or entity who can receive and use this information:
Name: Comprehensive Pain Solutions of Texas
Address: 1300 Medical Ave. Ste. 102 City: Plano State: TX Zip Code: 75075
Phone: (972) 598-9900 Fax: (972) 599-0742

Specific information to be disclosed:
□ Medical Record from (insert date) _____ to (insert date) _____
□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.
□ Other: _____

Include: (*Indicate by Initialing*)
_____ Drug, Alcohol or Substance Abuse Records
_____ Mental Health Records (Except Psychotherapy Notes)
_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)
_____ Genetic Information (Including Genetic Test Results)

Reason for release of information:
(Choose all that Apply)
□ Treatment/Continuing Medical Care
□ Personal Use
□ Billing or Claims
□ Insurance
□ Legal Purposes
□ Disability Determination
□ School
□ Employment
□ Other *(Specify)*: _____

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The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: _____ Day: _____ Year: _____.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____ Date: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____ Date: _____

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FINANCIAL POLICY

Thank you for choosing Comprehensive Pain Solutions as your healthcare provider. We are committed to your treatment being successful.

Please read and sign our financial policy prior to treatment. Please take note of the following office policies and let us know if you have any questions.

At the initial and all visits, the patient is responsible for all co-pay/co-insurance amounts as assigned by the insurance carrier, plus any applicable deductible amounts. If our office cannot verify insurance benefits, payment is due in full at check-in for your appointment. Please be advised that some, and perhaps all, of the services provided may be non-covered services under your plan and they may become your responsibility regardless of what type of coverage you have. You may be referred to a provider, specialist, and/or a facility that is out of network with your plan. Comprehensive Pain Solutions does our best to verify benefits, the patient is responsible for determining and verifying network status with the service provider.

If your insurance carrier sends payment directly to you, then payment in full is due at each visit. If you are waiting for coverage to become effective or have no medical insurance coverage, payment in full will be expected the day of the visit. For your convenience, we accept payment by cash, checks, and credit card.

If your insurance coverage changes, please notify us as soon as possible so we can make the appropriate changes to help you receive your maximum benefits.

We require that an adult (parent or legal guardian) accompany a minor patient unless prior written authorization is given to our office. The adult accompanying the minor patient is required to pay in accordance with our policies.

Should an overpayment occur on the deductible or percentage amounts charged, we will apply a credit to your account. A refund is available upon request. If you dispute a charge through your financial institution without a formal, written request for a refund, you may still owe the balance due and may result in, but not limited to, additional fees, collection, legal action, and/or release from the practice.

There is a $30.00 service fee on all returned checks in addition to the amount of the check. Non-sufficient funds (NSF) must be redeemed with certified funds (cashier's check, credit card, money order, certified check, cash) at or before the next office visit. Please note that if any unpaid balance is sent to an outside collection's agency, you will be subject to a fee in addition to the unpaid balance.

Print Name _____ Date _____

Signature _____

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No Show and Rescheduling Policy

Thank you for trusting your care to Comprehensive Pain Solutions of Texas. When you schedule an appointment, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our Appointment Cancellation/No Show Policy below:

- Any established patient who fails to show on time for a follow-up appointment, or cancels/reschedules an appointment within 24 hours of the scheduled time, will be considered a "No Show" and charged a $25.00 fee.
- Any established patient who fails to show on time for a procedure visit, or cancels/reschedules an appointment within 24 hours of the scheduled time, will be considered a "No Show" and charged a $100.00 fee.
- Any established patient with three "No Shows," will not be scheduled for future appointments.
- Any fees associated with "No Shows" are charged to the patient, not the insurance company, and are due at the time of rescheduling.
- Any new patient who fails to show for their initial visit will be rescheduled once. If the patient fails to show for the second visit, the patient will not be rescheduled.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. Exceptions to this policy may be made in the case of documented illness, unanticipated hospitalization, death in the family, or other extenuating circumstances.

Print Name _____ Date _____

Signature _____

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Assignment of Benefits

I hereby authorize Comprehensive Pain Solutions to file claims with my insurance company and to receive payment for my medical care and/or procedures**. I also understand that I am financially responsible for all charges not covered by my insurance for services rendered on my behalf or my benefits**. I further authorize payment directly to Comprehensive pain solutions of all insurance benefits related to my care. Comprehensive Pain Solutions has my permission to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions. **I understand that I am responsible for any copayment or co-insurance due at the time of any and all office visit(s) and/or procedures.**

Print Name _____

Signature _____ Date _____

Guardian Signature _____ Date _____
(if applicable)

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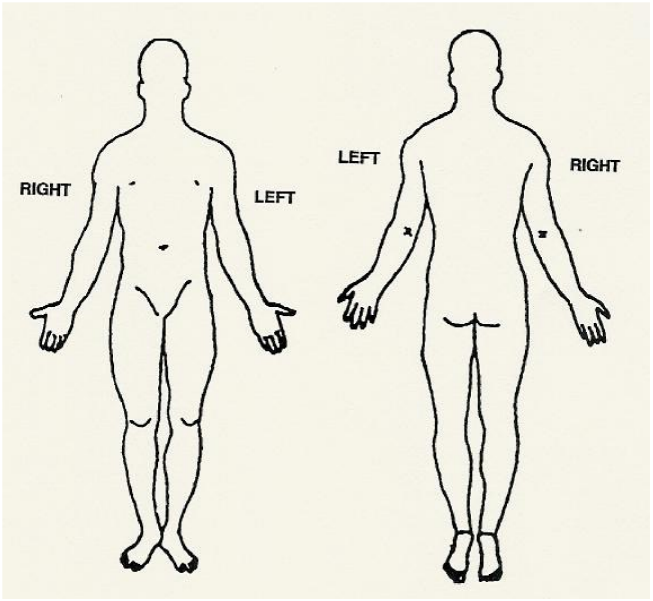
New Patient Pain Survey

Name: _____ **Date of Birth:** _____ **Today's date:** _____
Height: _____ **Weight:** _____

What is the reason for your visit today (circle one):

Low back pain Neck pain Arm pain Shoulder pain Knee pain Headaches Other: _____

Please circle the areas where you have pain:



Does your pain radiate? Where: _____

How would you describe your pain? (circle all that apply)

Sharp Dull Piercing Burning Aching Annoying
Shooting Sore Gnawing Stabbing Cramping
Agonizing Throbbing Electric shocks Miserable

How often is your pain present?
Brief/momentary Steady/constant Periodic/intermittent

When did your pain first begin? _____
How long has your pain been worsening? _____

How did your pain start?
Cannot identify Gradually Lifting/twisting Sports
Injury at home Injury at work Following surgery
Other: _____

What makes your pain better? (Circle all that apply)

Nothing Rest Walking Sitting Standing Lying down Bending forward Bending backward Heat/Ice Stretching

Other: _____

What makes your pain worse? (Circle all that apply)

Nothing Rest Walking Sitting Standing Lying down Bending forward Bending backward Heat/Ice Stretching

Other: _____

What is your pain rating (0= no pain, 10= worst possible): At worst? _____ At best? _____ On average? _____

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Are you experiencing any associated symptoms? (Circle all that apply)

Weakness Numbness Tingling Depression/Anxiety Flaccid paralysis Bladder/bowel incontinence

Other: _____

What activities are affected by your pain? (Circle all that apply)

Walking Dressing Bathing Eating Toileting Sleeping Household chores Working Socializing

Other: _____

What medications do you currently take for pain?

_____ _____ _____

_____ _____ _____

What treatments have you previously used for your pain and when? (Please circle and list approximate dates)

Physical therapy: _____ Home exercises: _____ Chiropractic: _____

Pain psychology: _____ Acupuncture: _____ Biofeedback: _____

Have you seen a previous pain management physician for this problem?

Name of physician/practice: _____ Dates seen: _____

Name of physician/practice: _____ Dates seen: _____

Have you seen a previous surgeon for this problem?

Name of physician/practice: _____ Dates seen: _____

Name of physician/practice: _____ Dates seen: _____

Please list all surgeries you have had related to this pain

Surgery: _____ Date: _____ Surgery: _____ Date: _____

Surgery: _____ Date: _____ Surgery: _____ Date: _____

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Are you diabetic? Yes No **What was your last Hgb A1C? _____** **What was your glucose today? _____**

Are you currently taking antibiotics or having dental pain, fever, chills, or other sick symptoms? Yes No

Please list all blood thinning medications you currently take: _____

Do you have an allergy to iodine based contrast dye? Yes No

Please list any other allergies you have: _____

Please circle any other medical conditions you have:

AIDS/HIV	Cancer	Heart attack	Osteoporosis	Other:
Acid Reflux (GERD)	Coronary Disease	Heart disease	Stroke	
Anemia	Depression	Hepatitis	Substance abuse	_____
Anxiety	Diabetes	Hernia	Thyroid problems	
Arthritis	Fibromyalgia	High cholesterol	Tuberculosis	_____
Asthma	Gout	Hypertension	Ulcers (gastric)	
Back injury	Head Trauma	Kidney disease		_____
Bleeding disorder	Headaches	Liver disease		

Are you experiencing any of the following symptoms? (Circle all that apply)

Fever	Bleeding gums	Ankle swelling	Joint pain	Numbness
Night sweats	Snoring	Cough	Back pain	Seizures
Weight gain	Dry mouth	Wheezing	Extremity swelling	Dizziness
Weight loss	Teeth problems	Coughing up blood	Neck pain	Headaches
Exercise intolerance	Ringing in ears	Abdominal pain	Difficulty walking	Tremor
Difficulty hearing	Sinusitis	Nausea/vomiting	Cramps	Depression
Ear pain	Chest pain	Diarrhea	Rashes	Suicidal thoughts
Frequent nosebleeds	Arm pain on exertion	Constipation	Non-healing areas	Anxiety
Sinus problems	Shortness of breath	Muscle aches	Loss of consciousness	Memory loss
Sore throat	Palpitations	Muscle weakness	Weakness	Fatigue

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Please list your preferred pharmacy:

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Please list any physicians currently involved in your care and related to the reason for your visit today:

Name: _____

Speciality (please circle): PCP Spine Surgeon Pain Management Neurologist Rheumatologist

Address: _____
_____
Phone: _____
Fax: _____

Name: _____

Speciality (please circle): PCP Spine Surgeon Pain Management Neurologist Rheumatologist

Address: _____
_____
Phone: _____
Fax: _____

Name: _____

Speciality (please circle): PCP Spine Surgeon Pain Management Neurologist Rheumatologist

Address: _____
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Screener and Opioid Assessment for Patients with Pain

Name: _____ D.O.B. _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings? 0 1 2 3 4

2. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4

3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? 0 1 2 3 4

4. How often have any of your close friends had a problem with alcohol or drugs? 0 1 2 3 4

5. How often have others suggested that you have a drug or alcohol problem? 0 1 2 3 4

6. How often have you attended an AA or NA meeting? 0 1 2 3 4

7. How often have you taken medication other than the way that it was prescribed? 0 1 2 3 4

8. How often have you been treated for an alcohol or drug problem? 0 1 2 3 4

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9. How often have your medications been lost or stolen?	0 1 2 3 4
10. How often have others expressed concern over your use of medication?	0 1 2 3 4
11. How often have you felt a craving for medication?	0 1 2 3 4
12. How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
14. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature: _____ Date: _____