COMPREHENSIVE
Pain Solutions
of Texas

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

PAIN HISTORY QUESTIONNAIRE:

Name: _____ Date: _____

Date of Birth: _____ Height: _____ Weight: _____

Please list the names of any healthcare professionals who have been involved in the evaluation and / or treatment(s) of your pain condition (please print names):

Referring Physician: _____

Primary Care Physician: _____

Neurosurgeon/Ortho Spine: _____

Physiatrist / Rehabilitation Specialist: _____

Orthopedic Surgeon: _____

Neurologist: _____

Pain Medicine Specialist: _____

Rheumatologist: _____

Other: _____

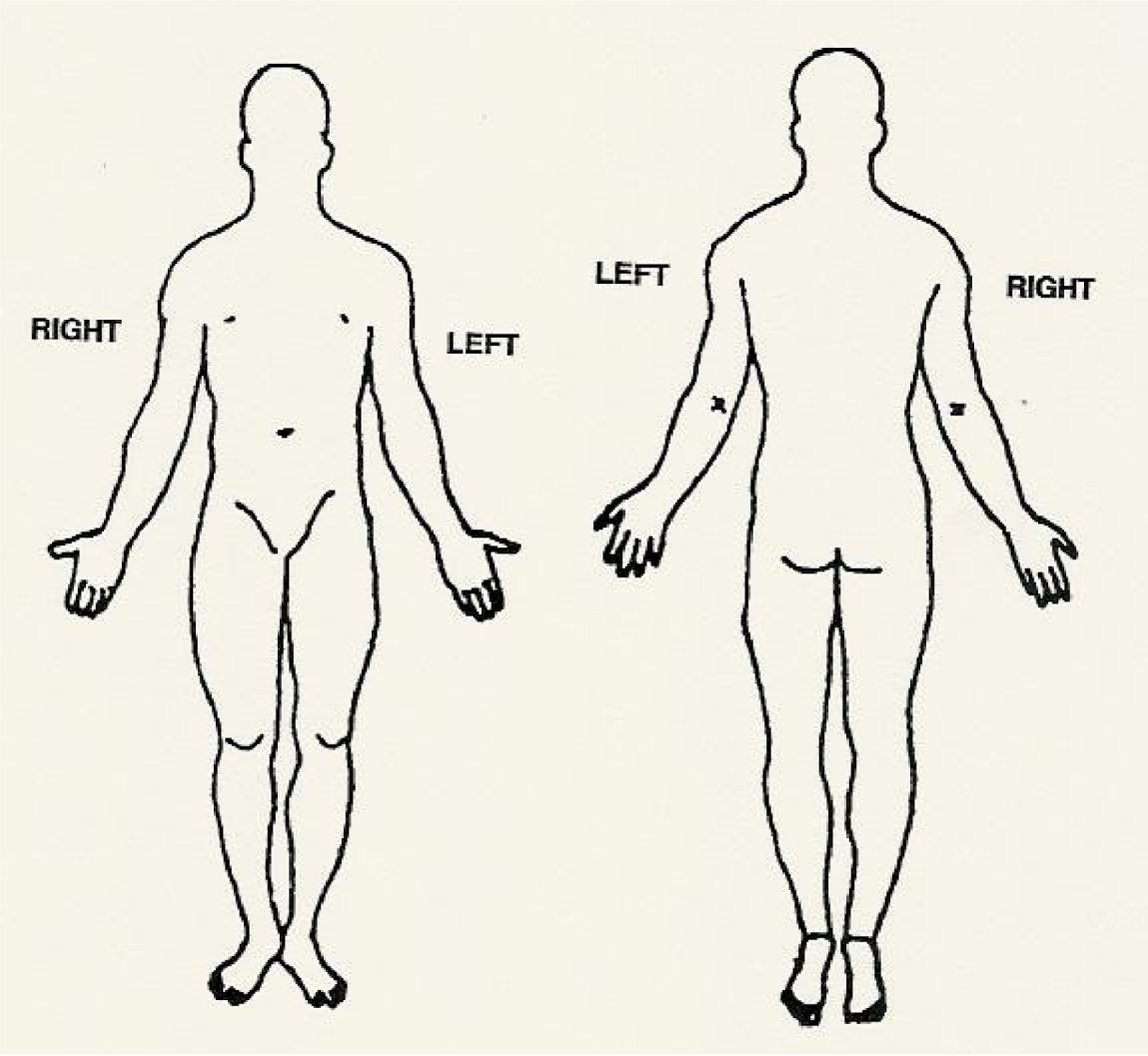
PLEASE DESCRIBE YOUR PAIN PROBLEM(S) Where is your pain?
Where does the pain spread or radiate? (Example – "Low back pain that radiates down the back of my left leg to the heel"):

_____

_____

_____

Please use the diagram below to demonstrate where your pain is located by shading the areas that are painful.



WHEN did your pain begin? (Please be as specific as possible - for example: "4 months ago")

_____

HOW did your pain begin?

	Date of Accident/Reason
__ Cannot identify	
__ Pain Started By Itself	_____
__ Injury or Accident at Work	_____
__ Injury or Accident at Home	_____
__ While lifting or twisting	_____
__ Sports injury	_____
__ Following Surgery	_____
__ Motor Vehicle Accident	_____
__ Other Reason (specify): _____	

WHAT DOES YOUR PAIN FEEL LIKE? Please circle <u>any</u> of the words below which describes the <u>character</u> of your pain:

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

HOW DOES YOUR PAIN CHANGE WITH TIME? Please circle any of the words below that describe the <u>pattern</u> of you pain:

brief/momentary steady/constant periodic/intermittent

Which activities/body positions IMPROVE your pain?

Nothing	Heat	NSAIDs/Tylenol
Sitting	Ice	Opioid pain medicines
Standing	Rest	Previous pain injections
Lying down	Exercise	Chiropractic
Position change	Elevation	Stretching
Bending forwards	Stretching	Physical therapy
Bending backwards	Yoga/Pilates	Acupuncture
Braces	Aquatherapy	Surgery

Which activities/body positions WORSEN your pain?

Cannot identify	Lifting	Going from sit to stand
Sitting	Twisting	Going from stand to sit
Standing	Exercise	Getting out of bed
Lying down	Walking down stairs	Previous surgery
Walking	Walking up stairs	Pushing/Pulling

Please rate your pain on a numerical scale:
(0 = no pain at all, 10 = worst possible imaginable pain)

At its worst: 0 1 2 3 4 5 6 7 8 9 10
At its best: 0 1 2 3 4 5 6 7 8 9 10
Average: 0 1 2 3 4 5 6 7 8 9 10

Which symptoms are associated with your pain (check <u>all</u> that apply):

__ Weakness of arm(s) - Left/Right/Both
__ Weakness of leg(s) - Left/Right/Both
__ Numbness of arm(s) - Left/Right/Both
__ Numbness of leg(s) - Left/Right/Both
__ Loss of bladder or bowel control
__ Tenderness of affected area
__ Cool, pale skin
__ Discolored or mottled skin
__ Temperature change in affected area
__ Decreased sex drive
__ Depression
__ Other: _____

__ Headaches
__ Pain with only light touch
__ Weight gain (lbs in last 6 mo?___)
__ Weight loss (lbs in last 6 mo? ___)
__ Difficulty sleeping
__ Pain awakens you at night
__ Fever

How does pain affect your lifestyle? (What can you no longer do because of pain?)

_____ _____
_____ _____

<u>Current pain medications:</u>

Please list the medications which you currently take strictly FOR PAIN:

Name of Pain Medication	Dosage and Number of pills per day
_____	_____
_____	_____
_____	_____

Previous pain medications:

Please list the medications which you have previously taken strictly FOR PAIN:

Name of Pain Medication	Dosage and Number of pills per day
_____	_____
_____	_____
_____	_____

Which Treatments have been used in the past for your pain? (Check all that apply)

	Date	Helpful?
__ Physical/Occupational therapy	_____	yes / no / somewhat
__ Regular exercise routine	_____	yes / no / somewhat
__ Epidural steroid injections	_____	yes / no / somewhat
__ Other nerve blocks / rhizotomies	_____	yes / no / somewhat
__ Chiropractic	_____	yes / no / somewhat
__ Psychotherapy / pain psychology	_____	yes / no / somewhat
__ Biofeedback	_____	yes / no / somewhat
__ Acupuncture	_____	yes / no / somewhat
__ Yoga / pilates	_____	yes / no / somewhat

WHICH DIAGNOSTIC STUDIES HAVE BEEN DONE TO EVALUATE YOUR PAIN PROBLEM?
(Please check all that apply)

	Ordering Provider
__ Blood Tests	_____
__ X-Rays	_____
__ MRI Scan	_____
__ CT scan	_____
__ EMG / Nerve Conduction Studies	_____
__ Bone Scan	_____
__ Other? _____	_____

MEDICAL HISTORY QUESTIONNAIRE

PAST MEDICAL HISTORY

Have you ever been diagnosed or treated for any of the following medical conditions? (Check all that apply)

__ AIDS/HIV
__ Acid Reflux (GERD)
__ Anemia
__ Anxiety disorder
__ Arthritis
__ Asthma
__ Back Injury
__ Bleeding disorder
__ COPD
__ Cancer
__ Coronary Artery Disease
__ Depression
__ Diabetes
__ Fibromyalgia
__ Gastric ulcers
__ Gout
__ Head trauma/injury
__ Headaches
__ Heart Attack (MI)
__ Heart disease
__ Hepatitis
__ Hernia
__ High cholesterol
__ Hypertension
__ Kidney disease
__ Liver disease
__ Osteoporosis
__ Sleep apnea
__ Stroke
__ Substance abuse
__ Thyroid problems
__ Tuburculosis

Other: _____

PAST SURGICAL HISTORY

Year _____ Surgery _____
Year _____ Surgery_____
Year _____ Surgery _____
Year _____ Surgery_____

ALLERGIES

Please list any allergies to medications:

Name of Medication	Reaction Experienced
_____	_____
_____	_____
_____	_____

Are you allergic to Iodine Contrast Dye (e.g. IVP Dye)? __Yes __No
If so, what type of reaction did you have? _____

REVIEW OF SYSTEMS

Have you been experiencing any of the following problems? (circle all that apply)

Fever	Chest pain	Acid reflux	Seizures
Night sweats	Shortness of breath	Diarrhea	Dizziness
Weight gain	Palpitations	Muscle aches	Bladder/bowel incontinence
Weight loss	Ankle swelling	Muscle weakness	Tremors
Exercise intolerance	Cough	Joint pain	Difficulty walking
Difficulty hearing	Wheezing	Difficulty walking	Depression
Nosebleeds	Coughing up blood	Skin discoloration	Anxiety
Dry mouth	Sleep apnea	Non-healing wounds	Suicidal thoughts
Snoring	Abdominal pain	Loss of consciousness	Drug or alcohol abuse
Sore throat	Nausea/vomiting	Numbness	Fatigue
	Constipation	Headaches	Heat/cold intolerance

Please list the medications which you currently take
FOR OTHER MEDICAL CONDITIONS:

Name of Medication

_____
_____
_____
_____

Name of Medication

_____
_____
_____
_____

Please list any herbal medications or suppliments you take:

_____
_____

_____
_____

Do you take Aspirin? __ Yes __ No

If you answered yes, when was your last dose? _____

Do you take any other blood thinners? __ Yes __ No
If you answered yes, please list? _____

SOCIAL HISTORY:

What is your current marital status? (Please circle and check one)

	How Long?
__ Single- Never Married	_____years
__ Married/Domestic Partner	_____years
__ Divorced/ Widowed	_____ years

With whom do you live? (Check all that apply)

__ I Live Alone
__ With My Parents
__ With Spouse/Domestic Partner
__ With Children (ages? _____)
__ With Others (Significant Other, Roommate, etc.)

Do you currently smoke cigarettes? __ Yes __ No
If yes, how many packs do you smoke during an average day? _____ Packs /day
If yes, for how many years have you smoked? ____ Years

Do you drink alcoholic beverages? ___ Yes ___ No
If yes, how often?

__ Never
__ Daily or More Often
__ Less Than Once A Week
__ Several Times A Week
__ Consider myself a heavy drinker

Have you ever been diagnosed with or treated for drug or alcohol abuse?
__ Yes __ No

If yes, when? _____ please describe _____
Are you currently or have you ever used illicit drugs. ___ Yes, ___ No.
If yes, what drug and when was the last time used? _____

WORK HISTORY:

What is your employment status? (Please check one)

__ Retired
__ Able to work but currently unemployed
__ Homemaker
__ Student
__ Working Part Time
__ Working Full Time
__ Involved in ongoing legal, disability or worker's compensation case

What is (was) your occupation or job title? (Please describe)

_____

COMPREHENSIVE
Pain Solutions
of Texas

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

PATIENT REGISTRATION

Personal Information

Name (*First,M.I.,Last)*_____

Date of Birth _____ Age _____ Male / Female SSN: _____

Driver's License # _____

Address_____ Home Phone_____

Mobile Phone _____ Email Address_____

Marital Status: single / married / widowed / divorced

Significant Other's Name_____

Race: Hispanic / Asian Caucasian / African American / Native American / Alaskan Native / Other

Ethnicity: Hispanic or Latino / Non-Hispanic or Latino / Other or Undetermined

Employer _____ Phone _____

Employer Address _____

Primary Care Physician _____

Referring Physician _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Responsible Party

Name of Subscriber _____ Relationship to Patient _____

Address_____

Phone Number _____ Date of Birth:_____ Social Security # _____

Employer _____ Phone Number _____

Employer
Address_____

Insurance Information

Primary Insurance Company _____ Phone Number _____

Address _____

Group # _____ Certificate or ID # _____

Insured's Name _____ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer _____ Phone Number _____

Employer
Address_____

Insured's Social Security # _____ Date of Birth _____ Male / Female

Secondary Insurance Company _____ Phone Number _____

Address _____

Group # _____ Certificate or ID # _____

Insured's Name _____ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer _____ Phone Number _____

Employer Address_____

Insured's Social Security # _____ Date of Birth _____ Male / Female

Pharmacy Information

Please provide your pharmacy information which all your medications are faxed, e-prescribed or called in to.

Preferred Pharmacy: _____ Phone #: _____

Pharmacy Address: _____

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.**

Patient Signature_____ Date _____

Guardian Signature (if applicable) _____ Date _____

Witness Signature _____ Date _____

COMPREHENSIVE
Pain Solutions
of Texas

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

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 do 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.

In consideration of other patients, please contact our office as soon as possible if you need to cancel or reschedule your appointment. Cancellations made less than 24 hours and no-shows will be subject to the following fees:

o $25.00 for a scheduled office visit

o $100.00 for a scheduled, in-office procedure visit

Please be sure to cancel at least 24 hours in advance to avoid these fees. Comprehensive Pain Solutions may not reschedule your appointment for no-shows or cancellations of less than 24 hours. Frequent NO SHOWS may result in release from the practice.

I have read and understand the forgoing Financial Policy and agree to abide by the terms of the policy.

Print Name _____

Signature _____

Date _____

COMPREHENSIVE
Pain Solutions
of Texas

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

NOTICE OF PRIVACY PRACTICES

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.

EFFECTIVE SEPTEMBER 2018

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("*medical information*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to Comprehensive Pain Solutions of Texas, PLLC, including its providers and employees (the "*Practice*").

I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of

the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. Quality Assurance. We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. Utilization Review. We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. Credentialing and Peer Review. We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

G. Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

H. Appointment Reminders and Health Related Benefits and Services. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone, SMS message, or e-mail) to provide appointment reminders and other information, with your written permission. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you.

I. Business Associates. There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

J. Individuals Involved in Your Care or Payment for Your Care. We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

K. As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

L. To Avert an Imminent Threat of Injury to Health or Safety. We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

M. Organ and Tissue Donation. If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

N. Research. We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "de-identified."

O. Military and Veterans. If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

P. Workers' Compensation. We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

Q. Public Health Risks. We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.

- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

R. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

S. Legal Matters. If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

T. Law Enforcement, National Security and Intelligence Activities. In certain circumstances**,** we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

U. Coroners, Medical Examiners and Funeral Home Directors. We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

V. Inmates. If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

W. Marketing of Related Health Services. We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved.

Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

X. Fundraising. We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Y. Electronic Disclosures of Medical Information. Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

III. OTHER USES OF MEDICAL INFORMATION

A. Authorizations. There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Psychotherapy Notes, Marketing and Sale of Medical Information. Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

C. Right to Revoke Authorization. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Comprehensive Pain Solutions of Texas, PLLC
Attn: HIPAA Officer
1300 Medical Ave., #102
Plano, TX 75075
(972) 598-9900

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

_____

Patient Name: _____
(Please Print Name)

Patient Date of Birth: _____

SIGNATURES:

Patient / Legal representative: _____ Date: _____

If Legal representative, relationship to patient: _____

Witness: _____ Date: _____

COMPREHENSIVE
Pain Solutions
of Texas

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

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., #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)*: _____

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: _____ Date: _____