Southwest Pain Group
Put your Pain in the Past.

REGISTRATION INFORMATION

(PLEASE PRINT)

Date: _____ / _____ / _____ Sex: ☐ M ☐ F Age: _____ Birthdate: _____ / _____ / _____

Patient Name: _____
Last Name First Name

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ - _____ - _____ Marital Status: _____

Employer: _____ Occupation: _____ Yrs. Employed: _____

Referring Physician: _____ Phone: (_____) _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Phone: (_____) _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Psychiatrist: _____ Phone: (_____) _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Drugstore Name: _____ Phone: (_____) _____ - _____

Emergency Contact Name: _____ Relationship: _____

Home Phone: (_____) _____ - _____ Work: (_____) _____ - _____ Cell: (_____) _____ - _____

Insurance Information: *(All blanks must be filled in)* ☐ Self-Pay ☐ Workers Comp Claim #: _____

Adjuster's Name: _____ Adjuster's Phone: (_____) _____ - _____

Primary Insurance: _____ Policy Holder: _____

ID: _____ Group: _____ SS# of Policy Holder: _____ - _____ -_____

Birthdate of Policy Holder: _____ / _____ / _____ Employer of Policy Holder: _____

Relation to Patient: _____

Secondary Insurance: _____ Policy Holder: _____

ID: _____ Group: _____ SS# of Policy Holder: _____ - _____ -_____

Birthdate of Policy Holder: _____ / _____ / _____ Employer of Policy Holder: _____

Relation to Patient: _____

I have completed this form fullyl and completely, and certify that I am the patient or duly authorized general agent of the patient, and authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services rendered.

Signature of Patient/Responsible Party: _____ Date: _____ / _____ / _____

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STATE REQUIRED ETHNICITY AND RACE QUESTIONS

(PLEASE PRINT)

BACKGROUND INFORMATION:

Texas law requires the Texas Health Care Information Council to collect information on the race/ethnic backgrounds of medical clinic patients. Medical practices are required to ask patients to identify their own race and ethnic backgrounds.

The data obtained through this process will be used to assist researchers in determining whether or not all citizens of Texas are receiving adequate health care.

If patients fail or refuse to identify their own race and ethnic backgrounds, facility staff will use its best judgment in making the identification.

QUESTIONS:

Mark the box that most accurately identifies the patient's ethnic background.

The Patient Is:

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ Patient refuses to answer the question

The Patient's Race Is:

- ☐ American Indian/Eskimo/Aleut
- ☐ Asian or Pacific Islander
- ☐ Black
- ☐ White
- ☐ Other *(Includes all other responses not listed above. Patients who consider themselves as multiracial or mixed should choose this category.)*
- ☐ Patient refuses to answer the question

The Patient's Primary Language:

- ☐ English
- ☐ Spanish
- ☐ Other

Patient Name: _____
Last Name First Name

Patient or Legal Guardian Signature: _____ Date: _____ / _____ / _____

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Notice of Privacy Practices

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

Southwest Pain Group (SWPG) is issuing this Notice of Privacy Practices about the information we share in common and your legal rights and our common duties with respect to your health information.

OUR PLEDGE TO YOU:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care, bill for your care, and comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether made by our staff and authorized trainees, or by your personal doctor. This notice tells you about the ways in which SWPG may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe our obligations regarding the use and disclosure of your health information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

Southwest Pain Group doctors, nurses, pharmacists, laboratory technicians, and other health care professionals may use health information about you to provide you with health care **treatment** or services. We may also disclose health information about you to others who are involved in taking care of you. For example, we may send health information about you to a specialist as part of a referral.

Southwest Pain Group may use and disclose health information about you to obtain **payment** for the treatment and services you receive from us. For example, we may send billing information to your insurance company or Medicare. We may also tell your insurance company about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. Southwest Pain Group may send you a statement of your account if payment is due from you. We may send the guarantor (responsible party for payment) monthly statements for charges for all patient's under that guarantor.

Southwest Pain Group may use and disclose health information about you to support our health care **operations**. For example, we may use health information to review the treatment and services and to evaluate the performance of our staff in caring for you. We may combine health information about many patients to decide what additional services we should offer. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

We may disclose information to notify **a family member or other person responsible for your care** about your condition, status, and location.

If you are admitted and unless you tell us otherwise, we may provide your name, location in the hospital, and your general condition (good, fair, etc.) for information to be included in a **patient directory** and make this information available to anyone who asks for you by name.

Southwest Pain Group
Put your Pain in the Past.

Notice of Privacy Practices Cont.

We may use and disclose health information to contact you for an **appointment reminder**, to tell you about **health-related services** or recommend **possible treatment options or alternatives** that may be of interest to you, or to contact you about supporting **our fund raising** efforts.

Subject to certain requirements, we may use or disclose health information about you **without your prior authorization** for other reasons:

We may give out health information about you for **public health** purposes; to **report abuse or neglect**; for **health oversight reviews**; in **research** studies; for **funeral arrangements** and **organ donation**; in response to special **law enforcement** requests, valid judicial or administrative orders, or for authorized national security and intelligence activities; for **workers' compensation** purposes; to **avert a serious threat** to your health or safety or those of the public or another person; and when **required by law**. If you are or were a member of the armed forces, we may release information about you as required by military command authorities or the Department of Veterans Affairs. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official.

In any other situation not covered by this notice, we will ask for your written **authorization** before using or disclosing your health information. You may **revoke** this authorization for any subsequent disclosures by notifying us in writing.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

You have the right to request in writing that you **inspect and obtain a copy** of the health information that we use to make decisions about your care. We may charge a fee for the costs of copying, mailing or other supplies and services associated with your request. If we deny your request to inspect or obtain a copy in certain limited circumstances, you may request that the denial be reviewed. Another licensed health care professional chosen by SWPG will review your request and the denial and we will comply with the outcome of that review.

If you believe that health information we have about you is incorrect or incomplete, you may make a written request to ask us to **amend information**. The request should state the reason for the amendment and specific information to be amended. The amendment must be limited to one page. Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously noted.

We may deny your request for an amendment if the information to be amended was not created by us, is no longer maintained by us, is not part of the information which you would be permitted to inspect and copy; or is accurate and complete. We will notify you if we deny your request for amendment and you may appeal, in writing, our decision. Any statements of disagreement or rebuttal will be linked to your health information and made a part of any subsequent disclosure we make of such information.

Southwest Pain Group
Put your Pain in the Past.

Notice of Privacy Practices Cont.

You have the right to make a written request for a **list of disclosures** we have made of your health information, except for uses and disclosures for treatment, payment, and health care operations, as previously described, and those for which you have authorized disclosure. Your request must state a time period which may not be longer than six years and may not include date April 14, 2003. We will not charge you for the first list you request within a 12-month period, additional requests will be charged according to our cost for producing 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.

You have the right to **request a restriction** on the health information we use or disclose about you for treatment, payment, or health care operations. There may be risks associated with such restrictions and we may ask you to acknowledge these risks in writing for certain requests you may make. **We are not required to agree to your request for restrictions** if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

You have the right to request, in writing without requiring you to state a reason, that **confidential communications** with you be made in an alternative manner or location. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

WRITTEN REQUESTS:

If you have any questions about this notice, please contact: Southwest Pain Group at 8230 Walnut Hill Lane, Suite 320, Dallas, Texas 75231 or call (214) 265-9991.

COPIES OF NOTICE AND CHANGES:

You have the right to obtain a paper copy of this notice at any time. We reserve the right to change this notice, and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future.

COMPLAINTS:

If you are concerned that your privacy rights may have been violated or you disagree with a decision we make about your health information, you may contact Southwest Pain Group at 8230 Walnut Hill Lane, Suite 320, Dallas, Texas 75231 or call (214) 265-9991. You may also send a written complaint to the U.S. Department of Health and Human Services. We can provide you the address.

Under no circumstances will we ever ask you to waive your rights under this notice or retaliate against you in any manner for filing a complaint.

Please sign the following form acknowledging that you have received our Notice of Privacy Practices, effective April 14, 2003.

Southwest Pain Group
Put your Pain in the Past.

Authorization to Release Information

Initials: ☐

I hereby authorize Southwest Pain Group to release any information acquired in the course of my examination or treatment for the purpose of determining eligibility for benefits and claims processing. Furthermore, I hereby authorize the payment directly to Southwest Pain Group, otherwise payable to me for the services rendered. I understand that I am financially responsible for any and all charges not covered by this authorization and all outstanding balances will be referred to collections. It is office policy that patients will be subject to Urine Drug Screens at any/all office visits and these charges will be submitted to your insurance. Be aware that due to your insurance policy, you may be billed at a later date.

Initials: ☐

ASSIGNMENT OF BENEFITS TO SOUTHWEST PAIN GROUP:
Medicare/Medicaid Patients ONLY: I hereby authorize Southwest Pain Group to furnish to my physician, any information obtained in the adjudication of any claims in regards to the services furnished to me under the Title XVII of the Social Security Act.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE AND HIPAA NOTICE:
By signing this form, you are agreeing that you have received a copy of our Privacy Notice, which describes how we use and disclose your health information and our HIPAA notice, which outlines standards and use of your protected health information. You have the right to refuse to sign the Acknowledgment, in which case we must document our good faith effort to obtain your acknowledgement and the reason why it was not obtained. Receipt of Privacy and HIPAA notice acknowledged.

Initials: ☐

Patient, spouse, legal representative, or beneficiary (patient's spouse may authorize disclosure of patient's health information only when the health information is for the sole purpose of processing an application for health insurance, for enrollment in a health care service plan or an employee benefit plan, and where patient is to be an enrolled spouse or dependent under the policy or plan.)

Initials: ☐

AUTHORIZATION TO VIEW MEDICATION LIST FROM e-PRESCRIBING SOFTWARE:
I hereby authorize Southwest Pain Group to view my medication profile available through e-prescribing software. I understand this list may not be comprehensive and is limited to the medications which have been prescribed to me electronically. It is my responsibility to provide my physician with a complete list of medications I am currently taking.

Initials: ☐

CONSENT FOR TREATMENT:
I voluntarily give my permission to the health care providers of Southwest Pain Group and such assistants and other health care providers as they may deem necessary to provide medical services to me. I understand by signing this form I am authorizing them to treat me for as long as I seek care from said providers, or until I withdraw my consent in writing.

Initials: ☐

ACKNOWLEDGEMENT OF MISSED APPOINTMENTS AND RETURNED CHECK POLICY:
I understand that Southwest Pain Group has the right to charge a non-refundable fee of $25 for missed office appointments, $50 for missed procedure appointments and $25 for checks returned unfunded.

RECEIPT AND ACKNOWLEDGEMENT OF THE ABOVE POLICIES/AUTHORIZATIONS/CONSENTS BY:

Person Completing Form: _____ Date: _____/_____/_____
Last Name First Name

Signature of Patient/Authorized Representative: _____

Relationship to Patient: _____

Southwest Pain Group
Put your Pain in the Past.

Insurance & Financial Policy

Thank you for choosing Southwest Pain Group. Our goal is to provide you with the highest quality care possible. We find that communication with our patients regarding our financial policy assists us in providing the best service to you. Therefore, we take this opportunity to answer some of the most commonly asked questions. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

INSURANCE INFORMATION:

We must emphasize that your health is our primary concern, regardless of your insurance. Because your insurance policy is a contract between you and your insurance company, please check with your insurance carrier to determine any pre-existing limitation or other benefit restrictions that you may have, prior to your appointment.

We will file your insurance as a courtesy and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

Most insurance companies do not cover 100% of the cost of services, and there is a portion that the patient is responsible for. There are several patient responsibility components that may apply to an insurance payment.

Co-Pay- A set dollar amount per office visit that is the patient's responsibility.
Co-Insurance- A percentage of the charge that is the patient's responsibility.
Deductible- A set annual amount that the patient is responsible for paying prior to his or her insurance making a payment.

Due to the contract you have with your insurance company, we are obligated to collect payment from you for your portion of the balance. All co-payments, co-insurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

To bill your insurance accurately and in a timely manner, we will need assistance from you. We ask that you provide our office with accurate demographic information (address, phone number, etc.) and proof of insurance. All patients will be required to show proof of insurance and a Government issued photo ID.

INSURANCE CHANGES:

If there are any changes in your insurance, you are required to call our office and give the detailed changes of your insurance at least forty-eight (48) hours to your appointment. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance.

MEDICARE:

We accept assignment with Medicare. Medicare pays 80% of their allowed amount after satisfaction of the yearly deductible. You are responsible for 20% of Medicare's allowed amount. All co-payments or deductibles are due and payable at the time of service.

SECONDARY & TERTIARY PLANS:

We will bill your secondary insurance as a courtesy. We do not bill tertiary insurance. If you have supplemental insurance to cover the portion of the charges that Medicare or your primary insurance carrier does not pay, please provide us with a copy of this insurance card. Medicare and secondary carriers do not cover some procedures and supplies. Please make certain that you understand which aspects of your treatment are covered prior to proceeding.

Southwest Pain Group
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Insurance & Financial Policy Cont.

PREAUTHORIZATION:
Please remember that it is up to you to understand the requirements of your individual insurance plan and know whether prior authorization from your insurance company is required.

NON-COVERED SERVICES:
Any care not paid for by your existing company insurance coverage will require payment in full at the time of services are provided or upon notice of insurance claim denial.

SURGERY & INJECTION FEES:
All co-pays, co-insurance, deductibles, and payments for non-covered surgical procedures are due prior to surgery. We will make every attempt to determine your coinsurance amount prior to your surgery. This will be based on your insurance benefits and an "estimate" of the services to be provided. We will provide you with that "estimate" & we will expect to collect that amount prior to the time of surgery. If any changes are made to the scope of services provided and the coinsurance amount has changed, we will either refund or bill you upon final resolution of your account. Fees are ultimately the responsibility of the patient, whether your insurance company pays or not, and are due within thirty days of your receipt of Southwest Pain Group statement.

NON-PAYMENT:
Please be aware that patient accounts over 180 days without satisfactory payment will be turned over to a collection agency and patients will face possible termination from the practice.

RETURNED CHECKS:
A $25.00 fee will be charged for any returned checks and we will report bad checks to the District Attorney's Office. We will be unable to accept your check for any services thereafter.

NO-SHOW/ MISSED APPOINTMENTS:
A scheduled appointment is a commitment of time between you and our practice, a time we have reserved just for you. If you are unable to keep a scheduled appointment, please cancel or reschedule your appointment at least 24 hours in advance to avoid a service charge and help us meet the needs of other patients. Patients who do not give a 24-hour cancellation notice will be charged a $25.00 fee for office appointments and a $50.00 fee for procedure appointments.

CHILDREN OF DIVORCED PARENTS:
Responsibilities for payment of patients, who are minor children, whose parents are divorced, rest with the parent who seeks treatment.

ACCOUNT BILLING QUESTIONS & REFUNDS:
Questions or concerns regarding your account or insurance claim should be directed to our business office staff. If your account has a credit balance, we will promptly release a refund check to you once your insurance carrier has processed all pending insurance claims remaining on your account. If you feel an error appears on the statement or if you have any questions or concerns; please contact our billing office immediately at (214) 389-9130.

Printed Name

Signature Date

Southwest Pain Group
Put your Pain in the Past.

Payment Agreement

Thank you for choosing Southwest Pain Group! First and foremost we are committed to the success of your medical treatment and plan of care. Please understand that payment of your bill is part of this treatment and care.

OFFICE VISITS & OFFICE SERVICES:
Patient's health insurance plans stat that payments including co-pays and deductibles are to be collected for office visits at time of service. Upon request a member of our Business Office staff will review any deductibles and out of pocket expenses you are responsible for as outlined by your insurance plan. If you have not met your annual deductible you are expected to pay for services.

DO I NEED A REFERRAL?
No. We see many patients who have sought us out via the web, or from recommendations of other patients, friends or family. If you have an HMO plan you are responsible to have a PCP send a referral to our office. If a current referral is needed for your appointment you may contact your PCP to request the referral faxed to our office or you can sign a waiver that states you are responsible for today's services and provide full payment or your appointment can be rescheduled when the referral has been obtained. We will let you know when your referral has expired. It is the patient's responsibility to confirm that your health insurance is contracted with Southwest Pain Group since agreements change annually.

SURGERY & INJECTION FEES:
Our office will complete any pre-certification or authorizations if required by your insurance company. A member of our Business Office will review any deductible and out of pocket expenses you will be responsible for as outlined by your insurance plan, we require that the patient responsibility is to be paid prior to the procedure being performed; this amount will depend on your policy. The amount you pay will be posted to your account as a pre-surgical deposit. We try our best to make the portion you are responsible to pay as exact as possible. However, please keep in mind the calculated amount is an estimated cost. Unfortunately there is always the possibility that after your insurance pays its portion we may owe you a refund or you may still have a balance due.

HOW MAY I PAY?
We accept payment by Cash, Visa, MasterCard, Discover, American Express or Check (with a copy of a valid driver's license or identification). Credit card payments are also accepted via telephone.

For your convenience, we have answered a variety of commonly asked financial policy questions below. If you need further information about any of these policies, please ask to speak with one of our Business Office Representatives.

IF YOU HAVE:	YOU ARE RESPONSIBLE FOR:
No Insurance/Self Pay	Payment is expected in full at time of service
Motor Vehicle Accidents	Southwest Pain Group does not file insurance claims for motor vehicle accidents. We DO NOT accept liens or Letters of Protection (LOP's). Payment is expected in full at time of service.
Commercial Insurance	Also known as indemnity, "regular" insurance or 80%/20% coverage. Payment of the "patient's responsibility" for all office visits and procedure will be expected at the time of your visit.
HMO & PPO Plans	If the services you receive are covered by the plan: All applicable co-pays and deductibles are requested at the time of the visit. If the services you receive are not covered by the plan. Payment is expected in full at time of service.

Southwest Pain Group
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Payment Agreement Cont.

IF YOU HAVE:	YOU ARE RESPONSIBLE FOR:
Point of Service Plan or Out of Network Plan	Payment of the "patient's responsibility" for all office visits and procedure will be expected at the time of your visit.
Medicare	We will file all claims to Medicare and any secondary insurance. It is your responsibility to provide our office with any supplemental insurance information. We will send you a statement for any charges not covered by Medicare and your secondary insurance.
Secondary/Supplemental	As a courtesy, we will bill your secondary or supplemental insurance. Once payments have been received from your insurance plans, any remaining balance is the patient's responsibility.
Worker's Compensation	If our office has received your claim information in a timely manner and authorization, no payment is necessary at the time of visit. If claim information and/or authorization has not been received payment in full is requested at the time of service.
MEDICAL IDENTITY THEFT PROTECTION: In February 2009 Federal Trade Commission's Identify Theft Prevention Red Flags Rule was enacted. Medical offices are mandated to confirm the patient's identity and validate medical insurance coverage to ensure the identity theft has not occurred. To safeguard your identity, we will make a copy of your valid picture ID issued by a local, state or federal government agency (driver's license, passport, military ID, etc.) and a copy of your current insurance card to confirm your identity.	

ACKNOWLEDGEMENT: I have read, understand and agree to the above Payment Policy. I understand that my co-payment, co-insurance and deductibles are due and payable at the time of service. I understand that charges not covered by my insurance company as well as applicable copayments and deductibles are my responsibility.

- *"In the event that outside collection and/or legal cost are incurred by this office to obtain payment due, responsible party agrees that they will be liable for any costs incurred."*
- *I authorize my insurance benefits to be paid directly to Southwest Pain Group.*
- *I authorize Southwest Pain Group to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.*

_____	_____	_____
Date	Name of Patient (Print)	Signature of Patient or Guardian
_____	_____	_____
Date	SWPG Representative (Print)	Signature of SWPG Representative

Southwest Pain Group
Put your Pain in the Past.

Communication Consent

I _____ authorize Southwest Pain Group to communicate via e-mail at the following e-mail address: _____ regarding my patient care. I authenticate all communication between Southwest Pain Group and the above e-mail address is from me. I approve all e-mail responses from Southwest Pain Group and grant full disclosure of information to the above e-mail address. I understand and acknowledge that communication over the internet is not secure, and that there is potential risk for compromise of personal and medical information during internet exchanges. I hereby release Southwest Pain Group from all responsibility related to exchange of personal and medical information via unsecured internet pathways.

Preferred method of communication regarding appointment reminders and follow-up care:

- ☐ Email me at: _____
- ☐ Call me at: (_____) _____ - _____
- ☐ Text me at: (_____) _____ - _____
- ☐ Fax me at: (_____) _____ - _____
- ☐ Mail me at: _____
  _____
- ☐ Other: _____
- ☐ Decline

Patient Name: _____

Patient Signature: _____ Date: _____

Southwest Pain Group
Put your Pain in the Past.

Patient Questionnaire

(PLEASE PRINT)

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

   Name _____ Relationship _____ Birth date ____/____/_____

   Name _____ Relationship _____ Birth date ____/____/_____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

   Name _____ Relationship _____ Birth date ____/____/_____

   Name _____ Relationship _____ Birth date ____/____/_____

3. Please print the address of where you would like your postcards and/or correspondence from our office to be sent if other than your home:

   _____

   _____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

   ☐ Yes ☐ No

5. Please print the alternative daytime telephone number(s) where you would like to receive communications regarding your appointments, lab and x-ray results, and other health care information:

   (_____) _____ - _____ (_____) _____ - _____

   I am fully aware that a cellular phone is not a secure and private line.

6. Can confidential messages be left on your answering machine or voicemail? ☐ Yes ☐ No

7. I am fully aware my health information will be transmitted by electronic transmission, fax transmittal, internet, or email.

Signature of Patient/Responsible Party: _____ Date: _____ / _____ / _____

Southwest Pain Group
Put your Pain in the Past.

Medication Policy

IN ORDER TO RUN OUR PRACTICE AS EFFICIENTLY AS POSSIBLE,
WE WOULD LIKE TO EXPLAIN OUR MEDICATION POLICY:

1. We do not refill medications over the phone or by fax. Please come to your appointment with all of your pain medications in the actual bottles. Please remember, the medications we prescribe should be taken only as directed, and should last until your next appointment with our office.

   It is our policy not to provide or refill medications early. If medications are taken more often than prescribed, or lost or stolen, they cannot be replaced.

2. If you have a change in your pain levels, we ask that you call immediately to make an appointment with our office. You will then receive an individual consultation as soon as our schedule will allow. These visits help us to closely monitor your condition and your response to medications.

3. We ask that our medication refill telephone line be used sparingly. Spending time answering pharmacy requests prevents us from caring for patients in the office.

4. Remember that your pharmacist is well-educated regarding medications and is a valuable resource for information.

Thank you very much for reviewing this policy.

I _____ have reviewed and understand the
Last Name First Name
Medication Policy of Southwest Pain Group.

Patient Signature: _____ Date: _____ / _____ / _____

8230 Walnut Hill Lane
Suite 320
Dallas, Texas 75231

9301 N. Central Expwy.,
Suite 200
Dallas, Texas 75231

4708 Alliance Blvd.
Suite 850
Plano, Texas 75093

Office Phone: (214) 265-9991 Office Fax: (214) 265-0789

Southwest Pain Group
Put your Pain in the Past.

Guidelines For Chronic Narcotic Administration

The successful management of chronic pain involves many modalities including, but not limited to, physical therapy, surgical consultation, injection therapy, stress reduction, biofeedback, and oral medications. Occasionally, upon the mutual agreement of the patient and the Pain Management physician, it may be necessary to institute long-term opiate administration to achieve satisfactory pain control. The following are guidelines that will be helpful in managing the long-term administration of narcotic medications. Prior to initiating this therapy, I would encourage you to read the following guidelines and discuss them thoroughly with the provider.

1. **Patient agrees to fill prescription medications at one pharmacy only**. This pharmacy will be responsible for all medications prescribed during treatment.
2. **Medication prescriptions should be obtained only from the pain clinic office**. "Doctor shopping" for additional pain medications from other physicians is discouraged, and if this occurs, will jeopardize the physician/patient relationship. Patients must make an office visit for their pain mediation refill. No refills are done over the phone or fax.
3. **Please take only the amount of medication prescribed**. Narcotic analgesics will hopefully make your pain more tolerable, but they should not be used to relieve stress or to promote sleep. If your pain worsens or if there is a change in your symptoms, please make an appointment to be seen in the office.
4. **Lost or misplaced medications or their prescriptions will not be refilled at an early date.**
5. **Emergency Room visits for pain medication are discouraged**. The Emergency Room is an inefficient way to achieve pain reduction and may involve a long wait and the risk that no medication will be dispensed. It is unlikely that the Pain Management physician will be available when you arrive in the Emergency Room.
6. **Sedatives or "nerve medications" are rarely useful in chronic pain management and will rarely be prescribed.**
7. **Patient also agrees to continue with other modalities of chronic pain management** as deemed appropriate by the referring physician and the pain clinic physician. This will most likely include but is not limited to: physical therapy, lifestyle and nutritional strategies, rehabilitation, psychology, pain management psychiatrist, re-evaluation by other specialists, relaxation therapy, counseling, and other methods to help handle the stress of chronic pain.
8. **Patient authorizes Southwest Pain Group to obtain information** concerning medications prescribed, amount, and frequency from pharmacies and other physician offices.
9. **Patient agrees to have a random drug screen** when ordered by a provider; as recommended by the team's medical board
10. **Patient agrees to report to any Southwest Pain Group practitioner any problems with memory disturbance or difficulty in remembering how and when to take their medications.**
11. **Patient understands that an exit strategy is always sought if possible.**

NARCOTIC THERAPY - SIDE EFFECTS, RISKS AND COMPLICATIONS

The patient understands that narcotic analgesics may result in physical dependence that may ultimately require slow weaning once the pain condition improves. Immediate discontinuation of this medication is not advised. Tolerance to the medication may develop after long-term usage which means that ultimately these medications may become less effective. Other side effects may include...

- Respiratory depression resulting in respiratory arrest and/or death, as well as resultant cardiac arrest and/or death.
- Tolerance and/or physical dependence necessitating tapered discontinuation of the medications.
- Withdrawal phenomenon with abrupt discontinuation of the medication causing significant side-effects such as palpitations, diaphoresis, elevated pulse and blood pressure.
- Disorientation, resulting in falls and significant injury.
- Constipation and bowel obstruction, possibly requiring surgical intervention and potentially ischemic (dead) bowel, sepsis and death.

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Guidelines For Chronic Narcotic Administration Cont.

- Allergic and/or anaphylactic reactions to the medications resulting in hypotension, tachycardia, arrhythmias, respiratory or cardiac arrest, and death.
- Potentiation of other sedative medications causing additive and/or synergistic interactions and greater than expected or enhanced side-effects (see above list).

PRECAUTIONS

1. Patients taking anticoagulants are at particularly high risk since any kind of trauma (falls,etc) could result in life-threatening hemorrhage, intracranial bleeding, and death.
2. Extremes of age. The very young and the elderly may exhibit marked and dramatic side-effects from narcotic medications, even in low doses.
3. Patients with other significant medical problems (heart or lung disease, other) are at increased risk for complications related to the use of narcotic medications.
4. Patients taking sedative medications or central nervous system depressants should use narcotics sparingly and in reduced doses if absolutely necessary, due to additive and/or synergistic interactions and greater than expected or enhanced side-effects.
5. It is especially important to keep your medications in a secure location, and preferably, under lock and key, to avoid others (including children) from obtaining access to these potentially deadly substances.
6. **Narcotic analgesics should not be used during pregnancy.**

WHAT NOT TO DO WHILE TAKING NARCOTICS

- Any kind of activity where judgment is required - i.e. signing important documents, caring for the sick, the elderly, or the very young.
- Driving a car, motorcycle, truck or any motorized device
- Operating machinery
- Working in high-risk areas (i.e. construction sites, elevated work sites, working with power tools, etc)
- Drinking alcohol is prohibited while on narcotics due to potent and unpredictable enhancement of central nervous system depression of these two substances when taken together.

All questions were answered to the patient's satisfaction. The patient was encouraged to ask any additional questions or seek clarification for anything which was not clear in the guidelines.

Additionally, non-narcotic management treatment options were offered. These were declined by the patient.

I have read the above guidelines and will make every effort to follow these guidelines during my chronic pain management.

Signature of Patient: _____ Date: _____/_____/_____

Printed Name: _____

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Southwest Pain Group
Put your Pain in the Past.

Advanced Practice Nurse/Nurse Practitioner Consent

The Physicians of Southwest Pain Group want you to know that they employ Advanced Practice Nurses (who are also called Nurse Practitioners) to assist them in a "team approach" to their high quality delivery of medical care.

An Advanced Practice Nurse (APN)/Nurse Practitioner (NP) is a Registered Nurse who has received advanced education and training in the provision of health care. Advanced Practice Nurses/Nurse Practitioners are not doctors. APN's/NP's of Southwest Pain Group can diagnose, treat, and monitor routine and complex pain disorders. If you are seen by an APN/NP, your doctor will review your care with the APN/NP as part of the care plan.

I have read the above and understand that in this practice a "team approach" is used, with my unique problems and/or needs presented and discussed with one or more physicians in the development of my care plan. I also understand that typically one MD will direct my overall care, but that from time to time I may be seen by any or all the practitioners in this practice, including a Nurse Practitioner.

I hereby consent to the services of a Nurse Practitioner for my health care needs.

I understand that I can refuse to see the Nurse Practitioner, and request to see a Physician. understand that this may require my appointment to be re-scheduled.

☐ **Please check this box to acknowledge that you have read and accept the above.**

_____ _____

Signature Date

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Southwest Pain Group
Put your Pain in the Past.

Date: _____ / _____ / _____

Last: _____ **First**: _____ **Date of Birth**: _____ / ____ / ____

Who referred you here? _____

Height: _____**ft** _____ **inches** **Weight**: _____

What problem are you here for today?

_____

Is your pain due to an injury? □ No □ Yes
Was your injury work related? □ No □ Yes
Explain how the pain started:

_____

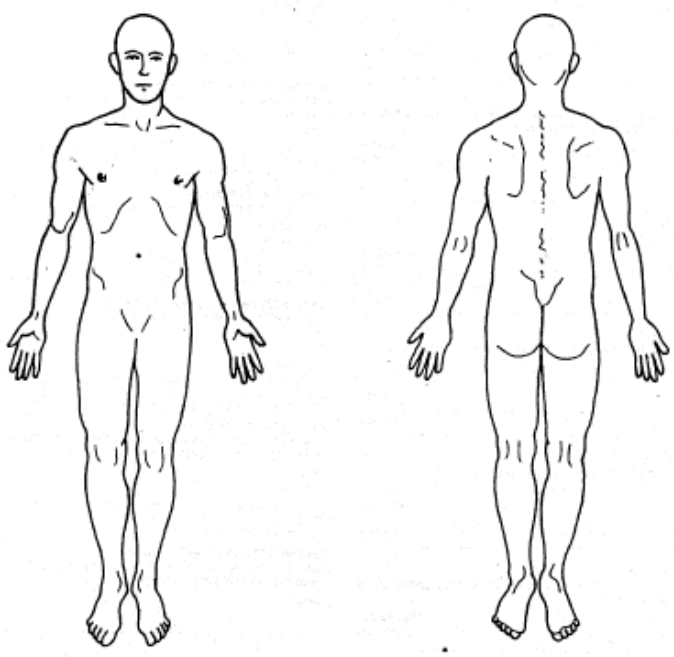
Date of onset (first episode)? _____

Have you had any previous episodes? (If yes, when?)

_____

Rate your pain on a scale of 1 (best) to 10 (worst) at its MOST SEVERE:
0 1 2 3 4 5 6 7 8 9 10
Rate your pain on a scale of 1 (best) to 10 (worst) TODAY:
0 1 2 3 4 5 6 7 8 9 10
Rate your pain on a scale of 1 (best) to 10 (worst) BEST:
0 1 2 3 4 5 6 7 8 9 10

Please shade in your areas of pain on the picture below:



Have you ever had any procedures (injections) for this or a similar problem? □ No □ Yes

List: _____
_____
_____

Have you had any prior surgery for this or a similar problem? □ No □ Yes

List _____
_____
_____

Over the past 1 to 2 weeks, is your pain getting? (Circle one)
Better Worse About the same

Location of the greatest area of pain _____
Do you have pain that goes down the arm or legs? □ No □ Yes

How would you break down the components of your pain? (Total 100%)

Back:	____ %	Left Leg:	____ %	Right Leg:	____ %	
Neck:	____ %	Left Arm:	____ %	Right Arm:	____ %	Other: ____ %

How would you describe the quality of the pain?

□ Burning	□ Numbness	□ Dull	□ Pins and needles	□ Stabbing
□ Throbbing	□ Aching	□ Shooting	□ Electrical	□ Stinging
□ Knife like	□ Sharp	□ Tingling	□ Toothache	□ Other_____

Southwest Pain Group
Put your Pain in the Past.

How frequently do you have your pain? (Circle all that apply)

Constant Most of the time Comes and goes Once in a while Hardly ever Other_____

In general over the past month is your pain worse in the:

Morning Afternoon Evening At night No Specific time

Do you have numbness or tingling? If yes, where? _____

Are you able to control urination? □ No □ Yes

Are you able to control bowel movements? □ No □ Yes

How does the following affect your pain?

	Worse	No change	Better
Lying down			
Standing			
Sitting			
Walking			
Exercise			
Going to work			
Medication			
Relaxation			
Cooking			
Twisting			
Sex			
Climbing stairs			
Walking down a hill			
Coughing & sneezing			
Bending over			
Arching your back			
Urination			
Bowel movements			

Please indicate previous treatments and results:

	Not Tried	Worse	No help	Some help	Moderate help	Profound help
Bed Rest						
Anti-inflammatory						
Muscle relaxants						
Narcotics						
Heat						
Ice						
Physical Therapy						
Chiropractic						
Injections						
Pain Clinic						

Other: _____

Have you had regular x-rays? If yes, when and where? _____

Have you had a CT scan? If yes, when and where? _____

Have you had a MRI scan? If yes, when and where? _____

What other tests have you had regarding this problem? _____

Past Medical History Please circle all that apply

Angina	Anxiety	Arthritis Asthma	Atrial Fibrillation	Bipolar Disorder
Bronchitis Chronic	Chronic Wounds	Congestive Heart Failure	Coronary Disease	Depression
Diabetes (Type 1 or Type 2)	DVT (leg clots)	Emphysema	Gastrointestinal Bleeding	Glaucoma
Headaches	Heart Burn, Reflux	Heart Disease	Hepatitis (A,B,C)	
High Blood Pressure	High Cholesterol	HIV/AIDS	Kidney Stones	MI/Heart Attacks
Osteoporosis	Pulm Emboli (lung clots)	Seizures Stomach Ulcers	Stroke	
Thyroid Disease (Low or High)	Urinary Incontinence	Urinary Tract Infections		

Southwest Pain Group
Put your Pain in the Past.

Please list any other Past Medical History

Past Surgical History (indicate date if known)

Appendectomy	Bariatric Surgery	Bowel/Stomach Resection	Cardiac Stents	Cataracts
Cervical Decompression	Cervical Spinal Fusion	Coronary Bypass Gall Bladder	Heart Valve	Hysterectomy
Lumbar Decompression	Lumbar Spinal Fusion	Pacemaker	Scoliosis Thoracic Decompression	
Thoracic Spinal Fusion	Thyroidectomy	Tonsillectomy		

Please list any other Past Surgical History

Family Medical History

GM = Grandmother, GF = Grandfather, M = Mother, F = Father, S = Son, D = Daughter
Example: Mother with Coronary Disease = Coronary Disease
GM, GF, (M), F, S, D

Angina
GM, GF, M, F, S, D

Anxiety
GM, GF, M, F, S, D

Arthritis
GM, GF, M, F, S, D

Asthma
GM, GF, M, F, S, D

Atrial Fibrillation
GM, GF, M, F, S, D

Bipolar Disorder
GM, GF, M, F, S, D

Bronchitis Chronic
GM, GF, M, F, S, D

Congestive Heart Failure
GM, GF, M, F, S, D

Coronary Disease
GM, GF, M, F, S, D

Depression
GM, GF, M, F, S, D

Diabetes (Type 1 or Type 2)
GM, GF, M, F, S, D

DVT (leg clots)
GM, GF, M, F, S, D

Emphysema
GM, GF, M, F, S, D

Gastrointestinal Bleeding
GM, GF, M, F, S, D

Glaucoma
GM, GF, M, F, S, D

Headaches
GM, GF, M, F, S, D

Heart Burn, Reflux
GM, GF, M, F, S, D

Heart Disease
GM, GF, M, F, S, D

Hepatitis (A, B, C)
GM, GF, M, F, S, D

High Blood Pressure
GM, GF, M, F, S, D

High Cholesterol
GM, GF, M, F, S, D

Kidney Stones
GM, GF, M, F, S, D

MI/Heart Attacks
GM, GF, M, F, S, D

Pulm Emboli (lung clots)
GM, GF, M, F, S, D

Seizures
GM, GF, M, F, S, D

Stomach Ulcers
GM, GF, M, F, S, D

Stroke
GM, GF, M, F, S, D

Thyroid Disease (Low or High)
GM, GF, M, F, S, D

Southwest Pain Group
Put your Pain in the Past.

Genetic Abnormalities

Please list any genetic/birth abnormality history
Example: Charcot-Marie-Tooth Disease None

Social History/Habits

Work: □ Employed □ Unemployed □ Retired □ Disabled

Current Occupation _____ Former Occupation _____

Marital Status: □ Married □ Single □ Divorced □ Widowed □ Domestic Partner

Alcohol: □ None □ Yes How many drinks/day _____frequency/week _____What kind_____

History of Alcohol abuse? □ No □ Yes

Tobacco: □ None □ Yes Chew or Smoke?_____ How many/day _____ Since_____

Other Recreational/Illegal Drugs: □ None □ Yes What kind_____ How many/day _____

Do you exercise? □ No □ Yes If yes, how much?_____

History of prior suicide attempts or contemplation of suicide? □ No □ Yes If yes were you treated? □ No □ Yes

History of opiate misuse or abuse? □ No □ Yes If yes were you treated? □ No □ Yes

Allergies

Please list any allergies No Known Drug Allergies

Medication

Please list all prescription and over the counter medications you are currently taking

Southwest Pain Group
Put your Pain in the Past.

REVIEW OF SYSTEMS: Please draw a circle around any symptoms or conditions in this section that you currently have, or had in the past. If your symptoms or conditions are not in the list, please write it in.

General:
anemia
bleeding disorder blood clots
phlebitis
psoriasis or other skin problems
osteoporosis
arthritis
neck pain
low back pain
sciatica
HIV or AIDS
Other_____
_____

Eyes, Ears, Nose, Throat:
loss or change of vision
eye pain or redness
excessive watering of eyes
double vision
loss of hearing
buzzing or noises in ears
ear infection or drainage
hoarseness
excessive sneezing
blocked nasal passages
nosebleeds
frequent running nose
difficulty swallowing
Other_____
_____

Respiratory:
wheezing
large quantity of sputum
bloody sputum
excessive cough
pneumonia
tuberculosis
shortness of breath with little exercise or at rest
night sweats
pain with breathing
emphysema
asthma
Other_____
_____

Cardiovascular:
chest pain
abnormal or fast heartbeat
abnormally low blood pressure
calf cramps with walking
excessive sensitivity of fingers/toes cold
varicose veins
rheumatic fever
high blood pressure
heart murmur
fibrillation
heart attack
frequent and marked swelling of ankles and feet
Other_____
_____

Gastrointestinal:
digestion difficulties
frequent nausea or vomiting
bloody vomitus
lack or loss of appetite
frequent stomach or abdominal pain
frequent belching
frequent loose bowel movements
recurring diarrhea
blood in the stool
hemorrhoids or piles
gallbladder trouble
frequent or severe constipation
persistent anal itch
diabetes
hepatitis
jaundice
ulcers
hiatal hernia
pancreatitis
anemia
Other_____
_____

Genitourinary:
urinary incontinence or dribbling
blood in urine
increased frequency of urination
chronic urgency or urination
difficulty starting/passing urine
painful urination
narrowing of urinary stream
flank pain and excessive urination
(Male patients only):
Penile pain
infection or sores
abnormality of testicle(s)
scrotal swelling
varicocele
prostatitis
tricture
sterility
difficulty in sexual functioning
Other_____

Female Patients Only:
breast discharge
breast swelling or lumps
breast pain
painful menses
breast infection
nipple changes or irritation
vaginal pain
vaginal infection
vaginal discharge or itch
known uterine fibroids/tumors
tubal infections
abnormality of menstruation flow
infertility or difficulty in becoming pregnant
marked changes in body hair distribution
difficulty in sexual functioning
Other:_____

Date of last menstrual period:_____
Number of pregnancies:_____
Number of live births:_____
Is it possible that you are pregnant?_____ (if so please notify Doctor)

Neurological:
Severe or frequent headaches
unusual head or neck tension
strokes
dizziness
fainting spells
seizures/fits/convulsions
shaking or twitching spells
paralysis of limbs
frequent or constant numbness tingling of body parts
severe lapses of memory
blackouts
Other:_____
_____

Emotional or Psychological:
emotional illness
depression
excessive worry
insomnia
recurrent feelings of loneliness or hopelessness
severe tension
feelings of worthlessness
recurrent fear
nervous exhaustion
frequent crying
nervous breakdown
frequent nightmares
hysterical attacks
constant unhappiness
Other: _____
_____

Southwest Pain Group
Put your Pain in the Past.

This Questionnaire has been designed to give us information as to how you pain has affected your ability to manage everyday life. Please answer every section and mark only the **ONE** box that applies to you.

Pain Intensity:
- The pain comes and goes and is very mild
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much
- The pain comes and goes and is very severe.
- The pain is severe and does not vary much.

Personal Care:
- I would not have to change my way of washing or dressing in order to avoid pain
- I do not normally change my way of washing or dressing even though it causes some pain
- Washing and dressing increase the pain, but I manage not to change my way of doing it
- Washing and dressing increases the pain and I find it necessary to change my way of doing it
- Because of the pain, I am unable to do some washing and dressing without help
- Because of the pain, I am unable to do any washing and dressing without help

Lifting:
- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table)
- Pain prevents me from lifting heavy weights off the floor
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most

Walking:
- I have no pain on walking.
- I have some pain on walking, but it does not increase with distance.
- I cannot walk more than one mile without increasing pain
- I cannot walk more ten ½ mile without increasing pain
- I cannot walk more than ¼ mile without increasing pain
- I cannot walk at all without increasing pain.

Sitting:
- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me from sitting more than one hour
- Pain prevents me from sitting more than ½ hour
- Pain prevents me from sitting more 10 minutes
- I avoid sitting because it increases pain right away

Standing:
- I can stand as long as I want without pain
- I have some pain on standing, but it does not increase with time
- I cannot stand for longer than one hour without increasing pain
- I cannot stand for longer than ½ hour without increasing pain
- I cannot stand for longer than 10 minutes without increasing pain
- I avoid standing because it increases the pain right away

Sleeping:
- I get no pain in bed
- I get pain in bed, but it does not prevent me from sleeping well
- Because of pain , my normal night's sleep is reduced by less than ¼
- Because of pain, my normal night's sleep is reduced by less than ½
- Because of pain, my normal night's sleep is reduced by less than ¾
- Pain prevents me from sleeping at all.

Social life:
- My social life is normal and gives me no pain
- My social life is normal, but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- Pain has restricted my social life and I do not go out very often
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain

Traveling:
- I get no pain while traveling
- I get some pain while traveling, but none of my usual forms of travel makes it any worse
- I get extra pain while travelling, but it does not compel me to seek alternative forms of travel
- I get extra pain while traveling, which compels me to seek alternative forms of travel
- Pan restricts all forms of travel
- Pain prevents all forms of travel except that done lying down

Changing degree of pain:
- My pain is rapidly getting better
- My pain fluctuates, but is definitively getting better
- My pain seems to be getting better, but improvement is slow at present
- My pain is neither getting better nor worse
- My pain is gradually worsening
- My pain is rapidly worsening